



Health Reform Initiatives in Central Asia

ZdravReform Program Final Report
June 2000

Acknowledgments

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Assisting Health Systems in Transition in Central Asia

USAID's health reform program in Central Asia emerged from the need to address deficiencies in health care financing and service delivery common in countries of the former Soviet Union. The Soviet health sector was well developed and emphasized universal access to health care but lacked effective incentives to improve quality and efficiency. The break-up of the Soviet system and the turbulent transition to market-based economies have had dramatic impact on the quality of health care in Central Asia. Current health systems suffer from chronic under-financing and inefficient use of available resources. Consequences for the population's health have been significant over the past ten years, with increasing rates of mortality, increasing morbidity from both infectious and chronic diseases, and declines in life expectancy.

The USAID-funded ZdravReform Program implemented by Abt Associates Inc. provided technical assistance in close partnership with the governments in Central Asia from 1994 to June 2000 to comprehensively reform and restructure the health service delivery and financing systems at both national and local levels. The goal of the technical assistance was to support government efforts to improve the Central Asian population's health by ensuring access to quality health care. Key program strategies included collaborating closely with key counterparts and reform stakeholders, developing a regional health reform model, and working intensively in selected demonstration sites.

The ZdravReform regional health reform model was designed with reform stakeholders to be comprehensive, addressing all aspects of the health care system and implementing them in an integrated way. Implementation began at demonstration sites within each country where working variations of the health reform model were developed and tested in well-defined geographic and administrative areas. Experience and lessons learned from demonstration sites allowed health system reform to be expanded and adapted for other sites, and eventually taken to the national level or used to inform the development of national health policy.

By the end of the project, the Central Asian reform model had been tested in more than 10 pilot sites. Due to the success of the ZdravReform Program, USAID awarded a follow-on contract to Abt Associates Inc. in June 2000. The ZdravPlus Program continues to provide technical assistance and training to improve the quality and efficiency of health care services in Kazakhstan, Kyrgyzstan, and Uzbekistan, and has begun providing limited technical assistance to help reform health systems in Tajikistan and Turkmenistan.

The following report serves as the final project summary of ZdravReform activities in Kazakhstan, Kyrgyzstan, and Uzbekistan. Country sections provide a summary of the policy environment for health sector reform, project accomplishments, and key results achieved during implementation of the ZdravReform health model in Kazakhstan, Kyrgyzstan, and Uzbekistan. The final section of the report provides key regional lessons learned from project implementation.

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The ZdravReform Regional Health Reform Model

The ZdravReform Program, in order to meet its ultimate goal of improving the health of Central Asian populations through increasing access to quality health care, has developed a guiding vision that consists of a restructured, realigned health delivery system that incorporates incentives to improve quality and efficiency and is connected to a population empowered to be responsible for their own health status.

In order to realize this vision given the peculiarities of the Soviet health system legacy, the ZdravReform Program, based on much consultation with government representatives and stakeholders throughout the system, developed a regional health reform model for implementation in Central Asia. Development of the health reform model required jointly identifying health sector problems, determining appropriate solutions, and developing a framework that allowed solutions to be implemented in a cohesive and integrated manner. Through this process, ZdravReform and key reform stakeholders defined three main components of the Central Asian health reform model:

- ✧ Restructuring the health delivery system and strengthening primary health care (PHC)
- ✧ Involving communities and the population in health issues and health reform efforts
- ✧ Implementing effective health care financing by introducing new provider payment systems and new management information systems

Improving the legal and policy framework for health reform and increasing public awareness of reform efforts are elements of each of these components.

Restructuring the Health Delivery System and Strengthening Primary Health Care

One of the most profound inefficiencies in the health care system is the imbalance between the hospital and PHC sectors. Hospitals consume more than 70 percent of the health care budget. The health delivery system inherited from the former Soviet Union can be likened to an inverted pyramid. The hospital sector at the top of the pyramid is over-developed and the PHC sector that should serve as the broad base of the pyramid is under-developed, under-financed, and under-utilized. Solving this problem requires

complete restructuring and strengthening of the PHC sector through the creation of new independent PHC practices.

As health reform efforts mature, the entire delivery system and the relationships between all levels of services must be addressed. The capability of the entire health delivery system to provide accessible, equitable, higher quality, more cost-effective health services to the population must be increased. In parts of Central Asia where new PHC practices have been established and strengthened, these providers continue to be constrained by both insufficient resources and the influence of polyclinics and hospitals. The relative roles and responsibilities of PHC practices, polyclinics, hospitals, and the sanitary-epidemiological stations (SES) must be redefined to facilitate shifting resources to PHC and allow PHC practices to continue to increase their autonomy, improve their clinical capabilities, expand their scope of services, and ultimately provide more cost-effective, family-oriented health care to the population.

There also are clinical obstacles to the development of the PHC sector that need to be addressed. PHC has been provided inadequately in the past through catchment area physicians with incentives to refer quickly to specialists. Training of PHC physicians is inadequate by Western standards so specialists in hospitals or polyclinics treated conditions that could have been effectively treated at the primary care level. Solving this problem requires introduction of general or family practice and upgrading of clinical skills. Clinical areas, such as reproductive health and infectious diseases, should be incorporated into PHC. In addition, extensive vertical health programs that were maintained by the Soviet system for tuberculosis, sexually transmitted infections (STIs), psychiatry, and oncology also eventually should be integrated into PHC.

Involving Communities and the Population in Health Issues and Health Reform Efforts

In the Soviet system, the population was not involved in decisions about their health care. They had limited rights as well as limited responsibilities. They were unable to choose their PHC provider and their health care provider did not give them information about their condition. Provider payment systems

funded the infrastructure of the health sector not the health services received by the population, and as the state provided everything, people did not take responsibility for their own health.

There are four major reasons to increase population involvement in decisions about their health care:

- ✍ Introduction of consumer choice is closely tied to the reorganization of the PHC system
- ✍ Informed consumers are active consumers, more likely to hold providers accountable providing an impetus to improve the quality and efficiency of health care
- ✍ Increased power in decision-making about health care can contribute to the desire for more democratic participation in other parts of society
- ✍ As government resources for health care shrink, the population needs to take more responsibility for their own health status and engage in healthier lifestyles

Addressing these issues requires redefining both population rights and responsibilities. The population should be given the right of free choice of PHC practice through an open enrollment process, as well as rights to obtain information about their health condition and to be covered under various health insurance systems. Population responsibilities must change as well, as consumers begin to inform themselves about their health status and to engage in healthier lifestyles.

Implementing Effective Health Care Financing by Introducing New Provider Payment Systems and New Management Information Systems

The legacy of the Soviet system and the turbulent transition to a market-based economy have had dramatic consequences for the health sector in Central Asia. The declining health sector resource base cannot sustain the current service infrastructure. The overly specialized system contains excess capacity and high fixed costs. Because facilities have historically received their funding based on a combination of capacity and utilization rates, incentives for providers have been to maintain large, inefficient physical structures and excessive medical staff.

The allocation of health resources in Central Asia has followed the traditional Soviet chapter budgeting process, allocating health funds

across facilities by input measures, such as the number of beds, rather than by the quantity and quality of services delivered. Budgets were guaranteed and providers did not have to compete to attract the population by providing lower cost, higher quality health services. The budgets were disbursed by budget chapters according to strict norms. Since budgets were required to be spent according to these chapter allocations, facilities could not use their resources in the most cost-effective manner.

New ways to pay health providers are needed in order to change the underlying incentives to introduce competition, encourage increased efficiency, and allow hospitals greater autonomy to allocate resources. Case-based and capitated financing systems are being introduced for hospitals and PHC facilities, respectively. Efforts also are being made to ensure that facilities are given more autonomy through “chapterless financing” in order to manage their resources more effectively.

In the former Soviet Union, the Ministry of Health collected enormous amounts of information on health sector budgets, service utilization, and health status indicators. The data, however, were not compiled in a way that facilitated analysis, and it was difficult to link costs with utilization or health outcomes.

To survive in the ongoing transition to a market economy, the inpatient and outpatient sectors must both function more as businesses. Hospitals must understand the costs of providing their services and develop plans to reduce costs, increase revenues, and produce an optimal mix of services. PHC providers must be concerned about the health of their practices as well as that of their patients, and they must market themselves to the users and purchasers of health care.

At the health purchaser level, health management information systems are required to support the design, implementation, and evaluation of new provider payment systems and quality assurance systems. At the health provider level, new management information systems are needed to provide health facility managers with tools to adapt to the new environment, support better decision-making and allocation of resources, and monitor quality improvements. New management techniques need to be introduced and new health management careers established, for example, practice managers for PHC entities.

Pursuing Targets of Opportunity in Kazakhstan

Introduction

Kazakhstan has the most rapidly changing and decentralized policy environment in Central Asia, which has presented both opportunities and challenges for implementing and sustaining health sector development activities. Over the past five years, Kazakhstan has experienced radical changes in government structure, including moving the capital, merging oblasts, merging ministries, and decentralizing authority from the national to the regional level. In the health sector, a complete national health insurance system was established, dismantled, and is again being considered as a health financing policy option. The ZdravReform Program worked closely with national and local leadership over the past five years to adapt the Kazakhstan country program to the particular needs of this dynamic environment. The approach to implementing the health reform model evolved to be flexible enough to pursue rapidly changing targets of opportunity, build fundamental capacity that is less affected by changes in leadership, and strike the appropriate balance between regional and national level activities.

This flexible approach to program implementation allowed the ZdravReform Program and country counterparts to achieve results in all four of the main program areas, the impact of which can be summarized broadly as: (1) developing, testing and implementing working models of comprehensive, PHC-centered health system development in two demonstration sites; (2) rolling out the demonstrations to two oblasts, one of which is in collaboration with the World Bank-financed Health Sector Project; and (3) developing innovative and replicable strategies to adapt the implementation of the health reform model in the context of rapidly changing leadership, priorities, and policies.

Policy Environment

Kazakhstan has a long history of experimentation and innovation in policy, both within the health sector and beyond. While still part of the Soviet Union, Kazakhstan initiated a health reform program in a region of Zhezkazgan during the New Economic Mechanisms (NEM) beginning in 1989. Kazakhstan also was the first Soviet republic to create its own State Property Committee and began privatization of state enterprises in 1991 before independence. The

Government of Kazakhstan has been quick to adopt models of reform from international experience, including a health insurance system based on Russia's system and a pension reform scheme modeled on reforms in Chile. The Government also has been quick, however, to abandon such experiments, often before implementation has progressed significantly enough to mature and be evaluated objectively. This dynamic environment and readiness to try, and just as quickly abandon, new policies has created opportunities for innovation, but more often has led to an unstable policy environment that inhibits more than encourages the risk-taking that is often needed for reform.

Another distinguishing characteristic of the policy environment in Kazakhstan is a high level of decentralization and regional autonomy. The degree of decentralization, which always has been strong in Kazakhstan, was further entrenched by a series of new laws and regulations passed since the beginning of 1999. With these trends in the devolution of policy and budget authority to the oblast and regional level, Kazakhstan is opting away from a national health care system and toward more variation in financing and service delivery policies. The highly decentralized system means that there is no clear, coherent health sector strategy, but it also means that there are often fewer barriers to reform at the oblast level even when commitment to reform is uncertain at the national level. This decentralization has greatly contributed to the effectiveness and innovation of oblast-level pilot reform sites.

History of Health Sector Reform

The history of health reform in Kazakhstan dates back to the 1989 NEM demonstration during Soviet times. Although the NEM demonstration was cancelled in 1990, some general principles of reform had taken root in Kazakhstan. In 1992, the government of newly independent Kazakhstan established three oblasts as new health sector demonstration sites: Zhezkazgan, South Kazakhstan, and Kokchetau. Under the new demonstration program, an area in Zhezkazgan Oblast that also was designated as a free economic zone, began a health insurance experiment in 1993. To establish an alternative source of financing for the health sector, the President of Kazakhstan extended the health insurance experiment nationwide in June 1995.

These events coincided with the start-up of the ZdravReform Program in late 1994.

From Intensive Demonstration Site to Targets of Opportunity

The ZdravReform Program initially concentrated its technical assistance in an Intensive Demonstration Site (IDS) in Kazakhstan. USAID, ZdravReform, and government counterparts selected South Kazakhstan Oblast based on the MOH designation of this oblast as a health reform demonstration site in 1992. Although this oblast had a history of experimentation with health reform, there were nonetheless political obstacles to implementing a comprehensive health reform program. Therefore, after a year of concentrating resources in the IDS with limited success, ZdravReform began to modify its implementation strategy from the IDS approach to one of following “targets of opportunity.” Under this modified approach, technical assistance was provided to oblasts that had already demonstrated real commitment and initial steps to undertake reforms.

Zhezkazgan Oblast became the first oblast to request ZdravReform assistance to further its health reform initiative under the new implementation strategy. In 1995 when the Government of Kazakhstan extended the small-scale insurance experiment in a region of Zhezkazgan to the entire oblast, Zhezkazgan became the first oblast in Kazakhstan to finance health care facilities through the Mandatory Health Insurance (MHI) Fund. With the introduction of health insurance, the Zhezkazgan health sector leadership seized the opportunity for fundamental restructuring of health care service delivery and financing. In June 1995, local officials in Zhezkazgan invited ZdravReform to observe the health reform process and make recommendations for technical assistance. ZdravReform began working with the Oblast Health Department and the MHI Fund to refine and expand new provider payment systems, restructure service delivery, embark on privatization, and create a truly integrated package of health reforms.

Less than one year later, Semipalatinsk Oblast also approached the ZdravReform Program for assistance to implement the health reform program that was approved by the Oblast government in December 1995. In Semipalatinsk Oblast a unique combination of reform-minded local administrative officials and an influx of international technical and material assistance

created an environment conducive to rapid and innovative reform. Following ZdravReform workshops and training seminars on health insurance implementation issues, the Oblast Health Department and MHI Fund jointly requested ZdravReform assistance in February 1996. When the Federal MHI Fund granted Semipalatinsk status as a pilot oblast in April 1996, ZdravReform developed a plan for comprehensive technical assistance to the Oblast.

Over two years, the ZdravReform Program concentrated its resources in these two sites. The initial results were quite rapid, because the policy environments in these oblasts were highly conducive to reform, and the health sector labor force was prepared for and receptive to change. Both Zhezkazgan and Semipalatinsk Oblasts had progressive leadership and a long history of being on the forefront of policy experiments. In addition, the highly decentralized government system in Kazakhstan allowed oblast leadership to adopt a pace of reform that was more accelerated than national reforms.

In both demonstration sites, PHC reforms were the centerpiece of the reform package. PHC restructuring was carried out, and clinical strengthening of the new PHC practices was begun. At the same time, new economic incentives were created for health providers with the implementation of per capita payment for PHC in both oblasts, and a case-based hospital payment system in Zhezkazgan. Information systems were established, and modern management techniques introduced. In both oblasts, PHC practitioners from the new practices organized non-governmental associations, which

A press conference on health reform issues in Kazakhstan



were active in policy dialogue and instrumental in helping to carve out a new role for PHC in the system.

Today, Zhezkazgan and Semipalatinsk Oblasts remain two of the leading demonstration sites in Central Asia. Zhezkazgan, for example, is one of few demonstrations sites where all health care resources have been pooled in the MHI Fund, thus avoiding the dual benefits package. This was possible because a strong Oblast Health Department was able to relinquish control of resources to the MHI Fund without sacrificing decision-making power in the health sector. Reforms in Zhezkazgan Oblast also demonstrated the power of private ownership of PHC facilities. Physician-owners have been extremely motivated to improve access for patients, increase their scope of services, and improve quality of care in order to attract new and keep existing patients.

Reforming primary care sector targets services and resources to vulnerable groups like mothers and children

Oblast Mergers and Move to the National Level

In 1997, Semipalatinsk Oblast was merged with East Kazakhstan Oblast, and Zhezkazgan Oblast was merged with neighboring Karaganda Oblast. The new oblast centers were located in East Kazakhstan and Karaganda, which led to an abrupt change in the health sector leadership in

Semipalatinsk and Zhezkazgan. Nearly one year of the program in Kazakhstan was spent salvaging the demonstrations in Semipalatinsk and Zhezkazgan. The effect of the oblast merger highlights both the risks and the benefits of a demonstration strategy.

Over the next year, ZdravReform continued activities in the new oblasts, but many of the reforms were stalled or reversed completely following the oblast merger. ZdravReform devoted significant time to policy dialogue with the new leadership to protect the health reform demonstrations. In Zhezkazgan, the reforms have been protected and expanded into all of Karaganda Oblast, which is now a prominent and innovative leader in health reform in Kazakhstan. In Semipalatinsk, the oblast merger weakened the rural reforms, and the demonstration site was reduced to Semipalatinsk city and two surrounding rayons.

This situation has recently begun to change with the new World Bank health sector loan, which became effective in August 1999. USAID committed to collaborate with the World Bank, with ZdravReform providing technical assistance to implement the World Bank-financed project. The World Bank loan initially designated Semipalatinsk Oblast as one of the project sites because of the health reform progress already achieved there. The World Bank-financed project combined with ZdravReform technical assistance served as a catalyst to expand the Semipalatinsk reforms throughout East Kazakhstan Oblast.

In many ways, the oblast merger facilitated, or even forced, the movement of the ZdravReform Program from oblast level demonstrations to expanding activities to the national level. This happened in part because the political obstacles following the oblast merger made it difficult to continue activities in the demonstration oblasts at the previous intensity. In addition, the former head of the Zhezkazgan Oblast Health Department and long time ZdravReform counterpart, Tolebai Rakhipbekov, became the chairman of the Committee on Health in the Ministry of Health, Education and Sport.

In a short time, restructuring of the PHC delivery system became a national policy under a Committee of Health decree. A PHC-centered health care system became an integral part of Kazakhstan's health policy agenda. Oblast and city officials throughout Kazakhstan began implementing PHC reforms, while a large number of health professionals were trained in



family medicine. Finally, new health sector NGOs and professional associations were established to advocate for further oblast and national level health reforms.

Experience working at the national level showed, however, that the oblast merger forced the ZdravReform Program to shift the focus to national roll-out prematurely. The conditions were not fully in place for national level roll-out of the reforms in Kazakhstan for several reasons. First, the national Committee on Health, having been reduced from the level of a Ministry, did not have adequate capacity and resources to embark on a national level implementation effort. Second, the existing demonstrations were not entirely mature, and the need remained for continued technical support from ZdravReform at a relatively intensive level. Finally, the other oblasts of the country did not have the necessary conditions in place to implement reforms without significant technical assistance. These oblasts, therefore, had difficulty implementing national reform legislation, creating situations that often discredited the reform initiatives themselves in these oblasts.

Therefore, while the convergence of events, both programmatic and political, allowed the ZdravReform Program to break through previous barriers and make significant inroads into national level health reform in 1998, it became necessary to return to the oblast level and continue to build the technical foundation for a slower-paced, more sustainable national roll-out of reforms. The foundation building for national activities includes deepening the reforms in the leading oblasts to create innovations that can be used in other oblasts, and the start-up of reforms in other oblasts to create the conditions necessary for national roll-out.

Results

Over the past five years, the ZdravReform Program has worked with the Government of Kazakhstan to create the legal and regulatory basis necessary to support health sector reform, and to develop, test and roll out working models of PHC-centered health reform. Even in the unstable policy environment discussed above, significant progress has been made in each of these areas. The following sections summarize results at the national level and in the demonstration sites in each of the four technical program components: 1) developing national policy and a legal framework for reform; 2) strengthening PHC; 3) increasing health care

financing and improving resource allocation; and 4) ensuring population involvement and choice. These results were achieved through the evolving ZdravReform program implementation strategy to adapt to the needs of this dynamic and decentralized policy environment, and often variable level of commitment to health sector reform at the national level.

National Policy and Legal Framework

Because of the rapidly changing policy environment in Kazakhstan, policy dialogue and technical assistance to monitor and provide input into the legal and regulatory basis for health reform has been a significant and resource-intensive activity in the Kazakhstan country program. The ZdravReform legal team has been instrumental in identifying key areas of policy dialogue, providing technical review and recommendations for draft laws and regulations, and serving as an important source of information and analysis for counterparts in the oblast demonstration sites to keep them apprised of the frequent changes in national policies, laws, and regulations and their implications for the demonstration programs.

ZdravReform has provided input into numerous health sector laws and regulations, improving their technical content and the feasibility of implementation. The ZdravReform Program has provided most significant assistance to improve the laws and regulations governing health financing and the flow of health care funds. The most recent iteration of these laws reflects ZdravReform recommendations and is expected to remove many of the previous barriers to financing health care facilities according to new provider payment systems.

In 1998, the restructuring of the PHC delivery system was incorporated into national policy through a decree of the national Committee on Health (Prikaz 500). This decree mandated that all rural and urban PHC providers be separated administratively from higher-level facilities. Although this decree was a positive step, because it provided the legal basis for national roll out of the PHC restructuring, the national health leaders attempted to implement the decree too quickly without adequate preparation, information, and support for oblast health officials and PHC physicians. The pressure to restructure the system too rapidly has created some opposition to PHC restructuring and reopened the debate in Kazakhstan about the most appropriate structure for PHC service delivery.

Pilot Project Succeeds in Integrating Diagnosis and Treatment of STIs into PHC

During the past decade, Kazakhstan has experienced a severe epidemic of syphilis. This epidemic has been aggravated by dramatic shortages of government revenue funding for STI services. To increase the coverage of health care for STIs while likewise containing costs, the integration of reproductive health services was advanced tremendously with a pilot program in Zhezkazgan Oblast to integrate the diagnosis and treatment of STIs into the scope of services of PHC practices.

ZdravReform led a coordinated effort to design and launch the pilot, which represents the first time ever in the former Soviet Union that the diagnosis and treatment of STIs was decentralized to the PHC level. Family physicians were trained on the syndromic management of three common STI syndromes: urethral discharge, vaginal discharge, and genital ulcer. From November 1999, Family Group Practices in Zhezkazgan started to treat patients with STI syndromes according to Kazakh national guidelines on syndromic case management. The local dermato-venereology dispensary functioned as the referral site, providing clinical advice to family physicians and laboratory services. The project was a joint collaboration with the Kazakhstan National STI Research Institute, the Zhezkazgan Regional Health Department, the Zhezkazgan FGPA, WHO and UNAIDS-funded University of Heidelberg. ZdravReform and other donors supported the STI pilot with clinical training, drugs and supplies, and an intensive population information and education campaign.

Findings from the pilot project after only five months showed increases in access to effective and affordable care and a reduction in the cost of STI services. The quality of STI care through family physicians was good, especially for patients with urethral discharge and genital ulcer. Patients appreciated the quality, confidentiality, and low cost of the services of their family physicians. Family physicians increasingly won the trust of young people. The cost of diagnosis and treatment of STIs through family physicians was low compared to the cost of treatment at the local dermato-venereology dispensary. Finally, collaboration and support from the dispensary through training and supervision enhanced the quality of family physician services.

The vision of a PHC-centered health care system, however, has become an integral part of Kazakhstan's health policy agenda. And while the national policy debate continues, oblast and city health officials throughout Kazakhstan are continuing to restructure their PHC delivery systems, and the Postgraduate Institute for Physicians is reaching a growing number of physicians outside of the demonstration sites requesting clinical training in family medicine. The core principles of PHC strengthening supported by the ZdravReform Program therefore will be relevant under any design of the health care system that Kazakhstan eventually chooses.

In addition to providing analysis and input into national laws and regulations, the ZdravReform Program also has provided assistance in the policy, legal and regulatory area to the oblast demonstration sites. An important contribution has been to analyze and draft reports on specific legal topics that have confusing and contradictory implications for the oblast demonstration activities. For example, when oblast officials were considering privatization as an option for PHC restructuring in Zhezkazgan and Semipalatinsk, the laws and regulations were complicated, contradictory, and open to wide interpretation. The ZdravReform Program prepared a report analyzing the implications and shortcomings of the existing legal and regulatory documents related to privatization. The report was distributed to oblast counterparts as well as national officials, and contributed to the suspension of privatization of health facilities until more clear regulatory guidelines could be established.

ZdravReform also provided specific assistance to the newly independent PHC practices in the demonstration sites and newly formed health sector NGOs in the areas of incorporation, taxation, and labor relations. ZdravReform's comprehensive analysis of laws and regulations on corporations and incorporation enabled family physicians in new PHC practices to make more informed decisions about whether and how to incorporate, and how to achieve the most favorable tax status. In addition, a ZdravReform document analyzing labor laws provided PHC practice owners and managers with crucial information to exercise greater flexibility in their staffing decisions and personnel management.

Finally, the ZdravReform Program has encouraged and supported the development of health sector nongovernmental organizations (NGOs) to give individual providers and patients

a new voice in the health policy process. Family Group Practices (FGPs) have organized themselves into nongovernmental professional associations, which are active in policy dialogue and instrumental in carving out a new role for PHC in the health care system. Family medicine trainers and pharmaceutical sector professionals also established professional associations. There are now five NGOs actively working as advocates for health sector change in Kazakhstan.

Strengthening Primary Health Care

Efforts to restructure the PHC delivery system in Kazakhstan, as in the other countries of Central Asia, have focused on creating a network of PHC practices that are financially, administratively, and sometimes physically independent from higher level facilities. The ultimate goal of these restructuring efforts is to increase the managerial autonomy and internal control that PHC providers have over their resources, so they can better adapt their services to the needs of their populations. These independent practices are then strengthened through clinical training and equipment so they can expand their scope of services, including integrating vertical programs such as family planning, tuberculosis, and other infectious diseases. The following sections provide greater detail about the process and achievements in PHC strengthening in Kazakhstan.

PHC Restructuring

In Kazakhstan, various models of PHC restructuring have been tested, including urban and rural models, physical co-location in polyclinics and separate physical structures located in the community, and private and government ownership. The key principles that are maintained in all of the models is that the entire population is covered by PHC practices that have greater financial and management autonomy and are strengthened clinically to expand their scope of services. All of the 453 PHC practices in the demonstration sites in Kazakhstan are registered as independent legal entities, so they are legally permitted to have their own bank accounts, which allows the PHC practices to be financed directly rather than through polyclinics and hospitals.

In urban areas, the first step to PHC restructuring has been reorganizing polyclinics and women's consultation centers into mixed polyclinics that serve both adults and children, and that also provide women's reproductive health services.

The next step of establishing the managerial and financial independence of the PHC providers has typically meant physically separating them from the polyclinic structure, although some PHC practices have been registered as independent entities while still located in polyclinics in Semipalatinsk city, Karaganda, and Ust-Kamenogorsk.

Therapists, pediatricians, gynecologists, nurses, and a practice manager staff the urban PHC practices. In Zhezkazgan/Satpaeva and Semipalatinsk cities, PHC specialists were trained (and they continue to cross-train each other) to become general or family practitioners. The practice manager is a new position that has been introduced to help the PHC practices begin to function more like businesses and to free head physicians from burdensome administrative work, so they can spend more time in clinical practice. The practice managers are instrumental in operating new health information systems and assisting the head physician to use the information for better decision-making. The ZdravReform Program provided training for all of the practice managers in Zhezkazgan/Satpaeva, and led a three-month intensive training course for the 30 new practice managers in Semipalatinsk.

A model of rural PHC restructuring was tested in Semipalatinsk Oblast, and is now being expanded throughout the demonstration oblasts. Because PHC providers in rural areas are already physically separated from hospitals and polyclinics, and the PHC system is not as fragmented as in urban areas, the existing physical PHC structure has been simply reorganized administratively and financially. To form rural PHC practices, the SVA and FAP system is being consolidated into SVA/FAP complexes, with a unified catchment area and a single budget. Physicians staff the rural PHC practices, though typically not the full complement of therapists, pediatricians, and gynecologists, and a practice manager, which may be shared with one or more other PHC practices. As in urban areas, the rural PHC practices are registered as legal entities so they can have their own bank accounts. There are currently more than 300 rural PHC practices in the demonstration sites in Kazakhstan.

With the exception of those in Zhezkazgan city, all of the newly formed PHC practices in urban and rural areas have remained government institutions. In Zhezkazgan, the network of PHC practices was privatized over a period of two

years, and all practices are now owned by the family physicians that manage them. The financing of these private practices is still almost entirely from public sources, however, and according to their contracts with government financing bodies, they provide all PHC services to the population free of charge.

There are currently more than 450 independent PHC practices in the two demonstration sites and roll-out oblasts in Kazakhstan. In Zhezkazgan and Semipalatinsk cities, 100 percent of the population is covered by an independent PHC practice. PHC restructuring based on the Zhezkazgan and Semipalatinsk models is successfully being rolled out to East Kazakhstan Oblast, in collaboration with the World Bank, and to Karaganda Oblast.

Expanded PHC Scope of Services

The restructuring of the PHC delivery system, particularly in the rural areas, is one of the least resource-intensive steps in the reform process, and therefore often has been implemented quite rapidly. To be effective in shifting resources and service delivery to the PHC sector, however, it is essential that restructuring be followed by the more difficult and resource-intensive step of clinical strengthening. In Kazakhstan, the ZdravReform Program has devoted significant resources to clinical strengthening, including clinical training, small grants to non-governmental PHC associations to purchase equipment, and the integration of vertical programs into the PHC scope of services.

The ZdravReform Program has collaborated with the Kazakh Postgraduate Institute of Physicians to train hundreds of physicians and nurses through a two-month intensive course in family medicine. ZdravReform has followed the family medicine training with targeted supplemental training in specialty areas that are important for family physicians, such as cardiology and gynecology.

In addition, clinical training has been provided in specific areas to support the integration of vertical programs into the PHC scope of services. In the last six months of 1999 alone, ZdravReform sponsored seven intensive training courses to train more than 400 physicians in acute respiratory infections (ARI), childhood diarrheal diseases (CDD), reproductive health, pediatrics, cardiology, and STIs. Training in STIs was provided as part of a pilot project to improve access to and decrease the cost of STI services.

To integrate the management of infectious diseases into PHC, ZdravReform also supported the pilot test and adaptation of the WHO protocol for the integrated management of childhood illnesses (IMCI) for the Central Asia and NIS region. Semipalatinsk city and two surrounding rayons were chosen as sites to test and adapt the WHO IMCI protocol, and to integrate IMCI into PHC. The ZdravReform Program has supported this pilot intensively through clinical training in ARI/CDD, immunizations, nutrition, maternal and perinatal health, rational pharmaceutical management, health management systems, and surveillance. ZdravReform also has coordinated with other donors, such as WHO and the World Bank, to secure the necessary drugs for the IMCI pilot.

In addition to clinical training, the ZdravReform Program has supported clinical strengthening of new PHC practices by providing limited amounts of basic equipment to the practices through the nongovernmental PHC practice associations. The Program provided technical assistance to develop appropriate equipment lists and awarded small grants to associations in Zhezkazgan, Semipalatinsk, and Ust-Kamenogorsk to purchase equipment. The ZdravReform Program also has collaborated closely with the World Bank to provide a more substantial base of equipment for PHC practices in all of East Kazakhstan Oblast through the World Bank-financed Health Sector Project.

Health Care Financing and Resource Allocation

ZdravReform assistance in health financing and resource allocation often has been driven by the volatile changes in the national policy in health financing over the past five years, but the underlying model and goals have remained consistent. The Program has provided assistance to improve the use of health care resources by creating a single purchaser of health care services that has the authority to pool funds at the oblast level and distribute payments to health care facilities without budget chapters according to new payment systems. In order to design and implement these new financing policies, the ZdravReform Program has directed significant technical resources to developing health information systems for both the purchasers and providers of health care. The program also has provided assistance directly to health care providers to improve their management and resource utilization decisions.

In spite of an unstable policy environment, with three different national health financing systems since 1998, the ZdravReform Program has made significant achievements in health financing and management in Kazakhstan over the past five years. Nearly 50 percent of health care providers are paid by new provider payment systems in the five demonstration sites in Kazakhstan, and 27 percent of providers are using modern management techniques. Most recently, national legislation was enacted that will remove many of the barriers to expanding and refining new provider payment systems. The following section describes the major challenges and achievements in improving health financing policy and resource use in Kazakhstan under the major national health financing regimes.

When the ZdravReform Program began in late 1994, the new mandatory health insurance system was about to be signed into law and was therefore the main focus for program activities in health financing. Before the health insurance system was implemented, ZdravReform argued for a single-payer system, under which the insurance fund would become the single purchaser of health care. The Government of Kazakhstan, however, ultimately opted to adopt the Russian model of health insurance, which created overlapping financing responsibilities for the Ministry of Health (MOH) and Mandatory Health Insurance (MHI) Fund. This institutional structure with a multi-payer system made it difficult to realize many of the potential gains of the insurance system. The dual benefits package and unclear financing responsibilities made conflict between the MOH and MHI Fund inevitable, which, among other factors, eventually contributed to the re-incorporation of the MHI Fund into the Ministry of Health, Education and Sport (currently the Agency for Health Care (AHC)) at the end of 1998.

Even given the obstacles presented by the institutional structure and the inexperience of the MHI leadership, however, the MHI system did serve as an instrument for change in the health care system in Kazakhstan. The MHI Fund was an eager counterpart for the ZdravReform Program, and made use of the combination of a new mandate and the availability of technical assistance to introduce change. Thus, the MHI Fund introduced innovations in provider payment systems, computerized information systems and quality assurance between 1995 and 1998. In addition, the opportunities presented by the off-budget status of the MHI Fund at least brought the concepts of pooling of funds and

chapterless financing into the health policy debate.

The advantages of the health insurance system were realized most successfully in the ZdravReform demonstration sites. Unlike in most oblasts, in Zhezkazgan and Semipalatinsk Oblasts, the relationship between the MHI Fund and Oblast Health Departments was cooperative, and the ZdravReform Program therefore was able to work with health leadership to seize the momentum of the health insurance system. Rapid progress was made in these oblasts in restructuring the delivery system together with the implementation of new provider payment and information systems.

Although the re-incorporation of the MHI Fund into the Agency for Health Care (AHC) in 1999 did create a single-payer system again, there were unintended consequences that have created difficulties for health financing reform. With the termination of the MHI system, all government health care financing was returned to the budget, and again subjected to the control of local finance departments. Returning all health financing to the budget had enormous implications for health financing reform initiatives because: (1) there was no longer an earmarked tax for health care, which threatened the overall level of funds available for health care; (2) health care financing was being returned to the level of budget administration (rayon, city and oblast), and therefore oblast level pooling of funds became more difficult; and (3) the Ministry of Finance and treasury stringencies were reintroduced into the allocation of funds across health care institutions and across expenditure categories within health care institutions.

Currently, the health financing system is again being reconsidered in Kazakhstan, and health insurance may be reintroduced. The ZdravReform Program has participated actively on working groups to analyze policy options, and has contributed several analytical documents to the debate. The Program presented guidelines for a strategic planning approach to health financing reform and completed an analysis of international experience with health insurance systems, including the first experience with health insurance in Kazakhstan. It is unclear which path Kazakhstan will choose for its health financing system.

The ZdravReform Program, however, has built capacity, provided analytical and technical tools, and contributed to legislation that together creates a strong foundation for the continuation

of financing reforms. New provider payment systems have been developed and refined, and new health information systems are operating in the demonstration sites. The foundation that is in place increases the probability that whichever new financing system Kazakhstan chooses will preserve the fundamental concepts of new health provider payment methods, and information and management systems that increase the effectiveness of limited health care resources and shift power to individual providers and patients.

Population Involvement and Choice

In the Soviet system, the population had limited rights as well as limited responsibilities for their own health care. They were unable to choose their PHC provider, and their health care provider did not provide them with information. One of the goals of health reform is to empower the population to take a more active role in their health care decision-making. Increasing population involvement requires redefinition of both population rights and responsibilities. Therefore, as in all of the Central Asia ZdravReform country programs, increasing the rights and responsibilities of the population for their own health care through information and choice has been a central component of the Kazakhstan program. The following sections describe the major activities and achievements in the areas of choice (open

Health promotion activities ensure that health messages reach the population in innovative ways



enrollment) and information (health promotion and population awareness).

Open Enrollment

A central change that is necessary to increase population rights and responsibilities is to give patients effective choice of their health care provider. If provider payment systems allow the money to follow the patients' choices, strong economic incentives are created for providers to change their behavior to be more responsive to patients.

ZdravReform has encouraged free choice by supporting open enrollment campaigns in which the population is given a fixed period in which to enroll in the PHC practice of their choice. Open enrollment campaigns in Kazakhstan have given the population the right to choose their PHC provider for the first time ever. In Zhezkazgan 85% of the population has actively enrolled in the PHC practice of their choice. Several re-enrollment campaigns also have been held in Zhezkazgan to give the population the opportunity to periodically change their PHC provider if they are not satisfied or feel they can get better service elsewhere. Open enrollment campaigns based on the Zhezkazgan model also have been held in Satpaeva and Semipalatinsk cities. Health officials from both Karaganda and East Kazakhstan Oblasts are eager to replicate the experience in the demonstration sites and conduct PHC open enrollment in their oblasts.

Health Promotion

For patients to exercise effective choice, they must be informed about the health care system and their own health. An important aspect of this component of the health reform model, therefore, is to raise public awareness about the health care system and provide information about health topics to the public to take responsibility for their own health. An important element of the ZdravReform Kazakhstan country program, therefore, has involved the development and dissemination of products to raise public awareness about health reforms and provide information to the public to take responsibility for their own health.

In addition to routinely incorporating population information and awareness activities into the work of the comprehensive health reform demonstrations, ZdravReform developed specific health information and communication products and activities. For example, ZdravReform

produced two-minute videos on such topics as family planning, ARI/CDD, tuberculosis, STIs, cardiovascular disease, and safe motherhood. These videos were aired on television channels throughout Kazakhstan. The ZdravReform Program also sponsored journalist contests to promote the dissemination of health messages on important public health topics through the routine work of mass media. The journalist contests received entries from journalists throughout Kazakhstan on tuberculosis, childhood infectious diseases, and reproductive health. Overall, the ZdravReform Program also has increased health awareness throughout the population with more than 500 video spots, 200 newspaper articles, 200 radio spots and journalism contests, all covering health topics that are important to assist the population to take greater responsibility for their own health.

Conclusion and Lessons Learned

As discussed above, although Kazakhstan has presented a somewhat unstable environment for health sector reform over the past five years, significant achievements have been made. The Kazakhstan country program therefore has yielded important lessons for health systems development in a dynamic and unstable context.

First, one of the major factors contributing to the success of ZdravReform during this time of great change in Kazakhstan has been the underlying conceptual health systems development model that has remained relevant regardless of the changes in leadership, decentralization, and different paths chosen in health financing policy. The specific strategies for implementing the model could be adapted over time and across sites according to the political context. The conceptual model also provided general guidance to health sector leaders in the demonstration sites, even when they were receiving conflicting messages from the national health policy debate.

Second, Kazakhstan is clearly moving away from a national health care system, and is instead

opting for more regional variation in health financing and service delivery policy. Experience from the ZdravReform Program in Kazakhstan has shown that decentralization may be beneficial for some aspects of health systems development. For example, decentralization can be helpful for accelerating oblast demonstration where oblast leadership can more readily move change at a faster pace than national leaders.

Experience also has shown, however, that it remains important for the national level to establish a broad policy and legal framework for the health care system. Kazakhstan has made steps toward deepening some components of the health reform model by institutionalizing them with national legislation. Examples include national-level legislation that provides the foundation for implementing a case-based hospital payment system and restructuring of the PHC sector. More work is needed, however, on a more comprehensive policy and regulatory framework to guide the overall development of the health care system.

Finally, the successes in the Kazakhstan country program were achieved where the program was able to focus on building fundamental capacity that is required for the reforms to be sustainable and that is less likely to be affected by changes in leadership. ZdravReform experience has shown that for successful capacity-building, it is important that the pace of reforms follow a natural progression of foundation-building and step-by-step implementation. If reforms are pushed too quickly by top-down planning and legislation, implementation gets ahead of capacity, and local partners become frustrated and are unlikely to claim ownership of the reform process. This outcome was witnessed when the Chairman of the Committee on Health in Kazakhstan attempted to restructure PHC provider payment systems too quickly. The greatest successes in Kazakhstan were achieved where reforms were implemented gradually and allowed to follow a natural process of expansion, so that capacity building was driven by demand from local partners.



Moving Towards National Health Reform in Kyrgyzstan

History of Health Sector Reform

Health reforms began in Kyrgyzstan in mid-1994 with the designation of Issyk-Kul Oblast as the national health reform demonstration site and the WHO-supported development of a national health reform plan termed the MANAS Program. From late 1994 to late 1996, the USAID-funded ZdravReform Program developed and implemented a comprehensive, integrated health reform model in Issyk-Kul Oblast.

Positive results obtained in Issyk-Kul Oblast facilitated development of a productive collaboration among the government, the World Bank, and USAID. In 1997, the World Bank and the USAID-funded ZdravReform Program collaborated to roll-out the Issyk-Kul health reform model to Bishkek City and Chui Oblast. Also in 1997, the ZdravReform Program was able to begin the process of institutionalizing health reform at the national level. In 1998, ZdravReform began the long process of rolling out the health reform model to Osh and Jalal-Abad Oblasts in South Kyrgyzstan.

One of the reasons for the success of health reform in Kyrgyzstan was the development and

implementation of a comprehensive, integrated health reform model that addresses the problems of the health sector. While operational strategies and plans have varied with the rapidly changing environment, the basic health reform model has remained the same. It has provided stability in an uncertain environment and guided the path of health reform.

Issyk-Kul Oblast Demonstration Site

The MOH of Kyrgyzstan chose Issyk-Kul Oblast as the national health reform demonstration site in mid-1994. In late 1994, health reforms were initiated with a series of training seminars introducing various concepts, including health delivery system restructuring, health management, health insurance, accreditation, and cost accounting. By the summer of 1995, ZdravReform had established a site office, staffed by an expatriate resident advisor and local staff. The office worked intensively on building a foundation and implementing the health reform model in Issyk-Kul Oblast over the next two years, supported by technical staff from the Almaty Regional Office. In mid-1997, the health reforms, though still fragile and unsustainable, had taken root and the process of widening (or rolling out) reforms through collaboration with national stakeholders and the World Bank began.

Design of the First World Bank Health Sector Reform Project

Kyrgyzstan designed and implemented the first World Bank Health Sector Reform Project in Central Asia. Many of the design assumptions and parameters from this project have carried over into the World Bank Projects currently being implemented (Kazakhstan and Uzbekistan) or designed (Tajikistan) in Central Asia.

As the Kyrgyzstan Health Sector Reform Project was the first in Central Asia, the World Bank strived to establish a balance between addressing the MOH's critical short-term health and humanitarian needs, and developing a more efficient, sustainable health delivery system for the long-term. The initial stages of design in early 1995 brought only limited success in finding this balance. For example, the MOH wanted the project to provide drugs. While the World Bank recognized and wanted to address this need, they also wanted to invest in

Progressive leaders in Kyrgyzstan have set the pace for health reform



improving the efficiency of the health delivery system to increase long-term sustainability.

In mid-1995, discussions between the USAID-funded ZdravReform Program and the World Bank design team contributed positively to establishing this balance. World Bank senior health advisors were impressed with the design of the Issyk-Kul Oblast demonstration and wanted to extend the health reforms to Bishkek City and Chui Oblast as a component of the World Bank Project. Including roll-out of the Issyk-Kul Oblast health reform model into the Project provided the balance that allowed project design to move forward.

Over the next year, the ZdravReform Program contributed substantial technical assistance to the design of the first World Bank Health Reform Project in Kyrgyzstan. When the project became effective in late 1996, ZdravReform began to collaborate with the Project in the roll-out of the Issyk-Kul health reform model to Bishkek City and Chui Oblast.

Crisis Surrounding the Role of Health Insurance

Extension of the health reforms to the national level was hampered by a crisis concerning the role of health insurance and the new Health Insurance Fund (HIF) in the health sector of Kyrgyzstan. On the positive side, resolution of this issue triggered the process of institutionalizing the health reforms at the national level.

The initial World Bank position was that health insurance was irrelevant to the World Bank Health Reform Project. However, it was ZdravReform's contention that introducing a new health purchaser into the health sector would have an enormous impact on the implementation of new provider payment systems, one of the core elements of the project. When health insurance was introduced and the HIF established in late 1996, the World Bank Project was stopped in order to resolve this issue and avoid the problems experienced by Russia and Kazakhstan.

The introduction of health insurance and the establishment of a new HIF as a second health purchaser in addition to the MOH created many problems in Russia and Kazakhstan. For example, health policy was not coordinated between the MOH and HIF and health sector functions were duplicated, increasing administrative costs. Restructuring the health

sector was difficult because two provider payment systems created contradictory financial incentives, and two benefit packages created inequity and confusion among the population. Providers were incapable of managing payment from two sources, and fraud and abuse increased.

In the winter of 1997, the ZdravReform Program, together with the World Bank and Kyrgyz counterparts developed a new concept, approved by the Government in mid-1997, called the Coordinated Policy for the Implementation of Health Reform and Health Insurance. This policy introduced MOH and HIF Jointly Used Systems to enable the MOH and HIF to function as a single-payer in the health sector while remaining separate institutions with separate sources of financing. The MOH and HIF Jointly Used Systems consisted of five systems – information, provider payment, accounting, quality assurance, and benefits coordination.

The MOH and HIF Jointly Used Systems functioned very well in the initial stages of health reform and over the next year the reforms in Kyrgyzstan progressed rapidly because the MOH and HIF coordinated health policy in an effective manner.

Results, Conclusions, and Lessons Learned

The health reforms in Kyrgyzstan continued to progress rapidly between June 1998-June 2000. The following sections provide an overall summary of accomplishments; describe the roll-out of the Issyk-Kul health reform model to Bishkek City and Chui Oblast through collaboration between USAID and the World Bank; describe the initial stages of institutionalization of the health reforms at the national level; describe the initial stages of roll-out of the Issyk-Kul health reform model to Osh and Jalal-Abad Oblasts; describe the initiation of the foundation-building stage in Naryn and Talas Oblasts; and give some specific program results.

Summary of Accomplishments

Kyrgyzstan continues to move forward implementing all the components of the health reform model. Over 400 new Family Group Practices (FGPs) have been established nationwide to strengthen primary health care. Clinical training has been provided to FGP physicians and nurses in Issyk-Kul Oblast, Bishkek City, and Chui Oblast, and to FGP physicians in the four pilot areas of Osh and Jalal-Abad Oblasts through the national Family Medicine Training Center (FMTC) in Bishkek

City and FMTC Affiliates in Issyk-Kul and Osh Oblasts.

A national Family Group Practice Association (FGPA) has been established in Bishkek City as an NGO with affiliates in Issyk-Kul, Osh, and Jalal-Abad Oblasts. A national Hospital Association has been established in Bishkek City as an NGO with affiliates in Osh and Jalal-Abad Oblasts. These NGOs have advocated and provided services to their respective members – FGPs and hospitals. In addition, they have contributed to the development of civil society and a democratic transition in Kyrgyzstan as increased power in decision-making about health care can contribute to the desire for more democratic participation in other sectors of the economy.

The health reforms have involved the population in decisions about their health care by redefining both population rights and responsibilities. One new right of the population is the right to choose their PHC provider. In Issyk-Kul Oblast, Bishkek City, and Chui Oblast, approximately 80 percent of the population has exercised this right by voluntarily enrolling in the FGP of their choice. In addition to new rights, the population also has new responsibilities, particularly responsibility for their own health status. The ability of the population to manage and improve their own health status is being enhanced through extensive health promotion campaigns.

New provider payment systems contribute to economic restructuring by introducing competition, increasing health sector efficiency, and allowing health providers increased management autonomy to allocate resources more effectively. A new case-based hospital payment system was developed in Issyk-Kul Oblast and implemented nationally by the Health Insurance Fund (HIF). Over 60 hospitals or almost all the general hospitals in the country now are receiving part of their revenue under this new case-based hospital payment system. A new hospital information system was developed to support this hospital payment system and more than 800,000 hospital cases have been paid nationwide using this information system.

New capitated rate payment systems in which FGPs are paid a capitated rate per enrollee have been developed and implemented. The national HIF has contracts under this new capitated rate system, paying over 400 FGPs in Issyk-Kul Oblast, Bishkek City, Chui Oblast, and Osh and Jalal-Abad Oblasts. Issyk-Kul Oblast also has

implemented this new FGP payment system using budget or general revenue funds as well as health insurance funds. A licensing and accreditation function has been established nationwide, requiring that hospitals and FGPs be licensed and accredited before being eligible to contract with the HIF.

New clinical and financial management systems for health providers have been developed and implemented. A December 1998 MOH decree cancelled old health statistics forms and replaced them with new clinical information forms, codes, and automated information systems that are being introduced in stages nationwide. New clinical protocols, health purchaser quality assurance systems, and health provider quality improvement techniques are being developed and implemented. Finally, a legal framework is being established to institutionalize the health reforms.

Implementation of all the components of the health reform model continues throughout Kyrgyzstan. It is important to note that Kyrgyzstan has adopted a very process oriented, step-by-step approach to health reform. A national MOH and HIF Joint Working Group develops health reform strategy that outlines both a broad vision and operational plans containing a series of steps required to realize this vision. Incremental steps are introduced which strengthen the foundation and produce small victories that lead to larger victories.

Many of ZdravReform's Central Asia program strategies have been developed and tested in Kyrgyzstan, including criteria for a successful demonstration project and the demonstration widening or roll-out process; collaboration with the World Bank; the contribution of health reform to economic restructuring and democratic transition; development of a successful regional program; and integration of infectious diseases and reproductive health into PHC to increase sustainability and health sector efficiency. In addition, Kyrgyzstan has contributed many "lessons learned" which inform and improve the health reform process throughout the Former Soviet Union.

Issyk-Kul Oblast Demonstration Site

The major accomplishments of the Issyk-Kul Oblast demonstration site can be summarized as follows:

- ✦ Eighty-one new FGPs were formed in stages from early 1995 through mid-1996. From

June 1998-June 2000, the legal status of the FGPs was solidified and technical assistance and training largely succeeded in establishing FGPs as the foundation of a new health delivery system structure.

- ✍ Through an evolutionary process reflecting increased autonomy at the FGP level, FGPs voluntarily merged to combine resources, resulting in 74 currently functioning FGPs in Issyk-Kul Oblast.
- ✍ FGPs were strengthened through the provision of family medicine training for FGP physicians and nurses in Issyk-Kul Oblast from 1996 through the present. The Family Medicine Training Center (FMTC) in Issyk-Kul Oblast is institutionalized as an affiliate of the Post-Graduate Institute's National FMTC.
- ✍ FGPs began to incorporate infectious diseases and reproductive health into PHC.
- ✍ A new health sector NGO, the FGPA, was established in 1996. The FGPA established a voluntary board structure and developed their capabilities to provide services to their member FGPs.
- ✍ Over 85% of the population was enrolled in FGPs as a result of intensive marketing campaigns held in stages over the last half of 1996. The population database based on enrollment then was strengthened and used as the basis for capitated rate payment to FGPs.
- ✍ Extensive health promotion campaigns on a variety of health topics were conducted using mass media (television, radio, and newspapers) and other channels such as information brochures and community meetings.
- ✍ Institutional capacity building and development of the Oblast HIF resulted in the existence of an entity capable of serving as a health purchaser.
- ✍ A new case-based hospital payment system was developed in Issyk-Kul in 1996 and became the basis of the National HIF hospital payment system initiated in late 1997. From June 1998-June 2000, the oblast hospital and all Central Rayon Hospitals in Issyk-Kul were paid under the new case-based hospital payment system.
- ✍ In the fall of 1998, the National HIF tested a new capitated rate payment system for FGPs in Issyk-Kul Oblast. All 74 FGPs in Issyk-Kul are now being paid under this new HIF system. In 1999, the National HIF extended this FGP capitated rate payment system to all FGPs nationwide.
- ✍ In 1998, a new FGP capitated rate payment

system for budget funds was developed and tested in Issyk-Kul.

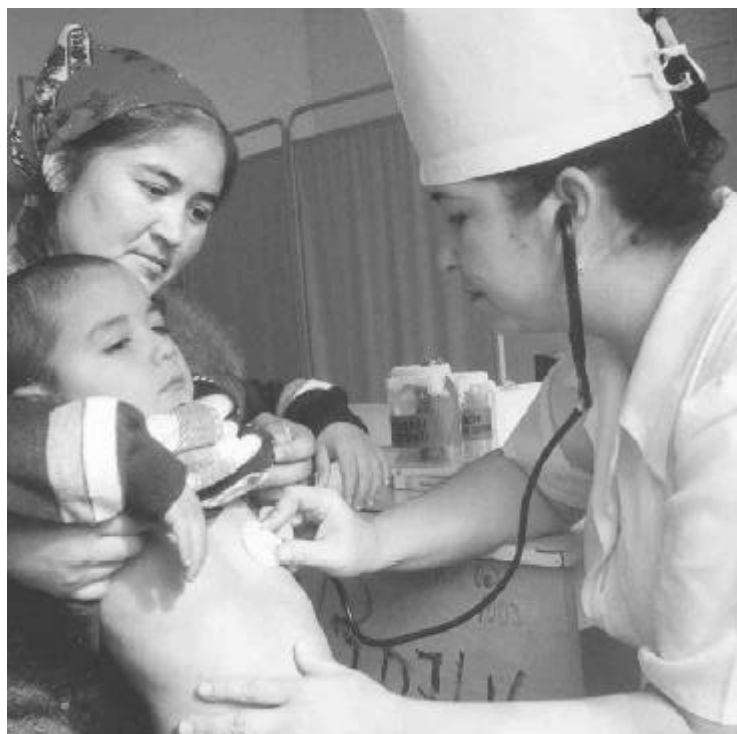
- ✍ New health information systems for both the health purchaser and health provider were developed, tested, implemented, and refined in Issyk-Kul Oblast and later implemented at the national level.
- ✍ A new health sector career was established and developed – practice managers for FGPs.
- ✍ A policy and legal framework for health reform was developed.

Roll-Out of the Health Reform Model to Bishkek City and Chui Oblast

In early 1997, experienced local staff were relocated from Issyk-Kul to Bishkek in order to establish an office and begin implementation of health reform in Bishkek City and Chui Oblast in collaboration with the World Bank. Because the Kyrgyz Government did not want to borrow substantially for technical assistance the basis of World Bank and USAID collaboration was formed on the following principle – USAID provides the significant technical assistance for which the government was reluctant to borrow and the World Bank loan provides substantial investment in commodities and political leverage.

The roll-out of health reforms to Bishkek City and Chui Oblast moved rapidly. By late 1999, 108 FGPs had been formed in Bishkek City and 144

Restructuring service delivery and improving financing are not sufficient to drive health reform in Central Asia – the basic nature of clinical practice must be changed



Reform Efforts in Issyk-Kul Oblast Trigger National Reform Processes and Continue to Identify and Overcome Reform Barriers

While the Issyk-Kul Oblast demonstration has been a success, experience has shown that continued support is necessary for a number of reasons. First, although the basic ZdravReform health reform model was well established by 1995, lessons learned from implementation have ensured that operational strategies continued to evolve. Many of the early adjustments to the model were based on experiences in Issyk-Kul. For example, it became clear that health delivery system restructuring and changes in health financing were not sufficient to drive health reform—the basic nature of clinical practice had to be changed. This resulted in an increased emphasis on family medicine clinical training, a shift in focus that has continued to the present day.

Second, in the early stages, the health reforms were very fragile and not sustainable. Even though 74 new PHC entities called Family Group Practices (FGPs) were formed, their role in a health sector dominated by hospitals remained uncertain. Until the FGPs were strengthened and their scope of service expanded, resources and service provision could not be transferred from hospital care to a more cost-effective PHC sector. In other words, though restructuring the health delivery system and building a new, more efficient PHC sector is vital to the success of health reform, the roles and relationships between PHC, outpatient specialty care, and inpatient care also must be redefined.

Third, the process of rolling-out the Issyk-Kul health reform model to the entire country of Kyrgyzstan required continued visible success and lessons learned from the Issyk-Kul Oblast demonstration. Health reformers in other parts of Kyrgyzstan needed Issyk-Kul Oblast to convince an entrenched and unprogressive health sector that health reform was a necessary and positive change.

A final reason why continued support for the Issyk-Kul demonstration site was necessary was that health reform is a step-by-step process where many subsequent steps are built on the foundation established in prior steps. For example, until FGPs are strengthened through clinical training, the scope of services they provide to the population cannot be expanded and solidified by the financial incentives of new provider payment systems. Also, health authorities are understandably reluctant to grant FGPs more management autonomy until their capabilities have improved. Many of these subsequent steps are now being realized in Issyk-Kul.

FGPs had been formed in Chui Oblast. As of June 2000, the task of strengthening FGPs was proceeding well as FGPs had received equipment, renovations, and clinical training. In late 1998, over 80% of the population of Bishkek City and Chui Oblast, more than one million people, exercised their right of free choice of PHC provider and enrolled in the FGP of their choice. Health promotion campaigns began to increase the responsibility of the population for their health status. National health sector NGOs, the FGPA and Hospital Association, were established, and their capability to advocate and provide services to their members increased. New provider payment systems and health information systems were developed, tested, and implemented under the HIF.

As in Issyk-Kul, health reform in Bishkek City and Chui Oblast has taken root, but is not yet sustainable. Progress continues under the USAID and World Bank collaboration to work with oblast and city health officials to strengthen the health reform.

Institutionalization of Health Reform at the National Level

A process-oriented approach was established at the national level to develop the policy and legal framework for health reform and a step-by-step approach to implementation. A MOH and HIF Joint Working Group was established to develop health policy, strategies, and operational plans. Technical Joint Working Groups also were established to address issues such as clinical information, provider payment, pharmaceuticals, and quality assurance. The Joint Working Group process was very successful in developing a health policy framework.

Work began to establish a legal framework based on the health policies developed by the MOH and HIF Joint Working Group. Many pieces of the legal framework have been put in place over the last few years. For example, national FGP regulations, HIF organization and provider payment regulations, regulations for health information systems, and important government decrees such as reinvestment of savings in the health sector have been approved. However, much more work is needed, particularly in the areas of allocation of budget funds, continued restructuring of the health sector, and clinical practice.

In addition to establishing a policy and legal framework for implementation of health reform

at the oblast level, many elements of health reform also were implemented at the national level. As Kyrgyzstan is a small country, it was decided that many of the provider payment systems and health information systems could be implemented nationally.

In late 1997, the HIF began implementation of a new national case-based hospital payment system. Over 60 hospitals, or almost all the general hospitals in Kyrgyzstan, are currently being paid under this system. In 1998, the HIF began contracting with FGPs as they were formed, paying them through a capitated rate payment system.

Extensive health information systems have been developed and are being implemented at the national level. In December 1998, a MOH decree cancelled many of the old health statistics forms, replacing them with forms and systems developed by the ZdravReform Program. This was a major step on the road to sustainability. While the new health information systems developed by ZdravReform operated the new provider payment systems, contributed to quality assurance and research, and provided better data for decision-making for both health purchasers and health providers, the new information systems were running parallel to the old systems. Relinquishing the old system allowed the new health information system to develop more rapidly and cost-effectively.

As discussed above, Kyrgyzstan made extremely rapid progress in the implementation of health reform from early 1997 through mid-1998. However, in mid-1998, progress slowed as political events resulted in a break-down of the coordinated MOH and HIF health policy. This lack of coordination of health policy between the MOH and HIF led the MOH to recognize that it was time to establish a health sector institutional structure viable in the long-term.

In December 1998, Kyrgyzstan took another major step forward by merging the HIF under the MOH to create a single payer in the health sector. The MOH and HIF Jointly Used Systems had bought time and allowed the health reforms to progress rapidly by avoiding the problems faced by Russia and Kazakhstan. However, the pace of reform had slowed significantly because of the inability of the MOH and HIF to coordinate policy.

There are several reasons why a single payer is the most appropriate health purchaser

institutional structure in Kyrgyzstan. First, it allows the major advantage of the Soviet system to be retained – universal coverage with relatively equal access and equity for the population. A multi-payer system on the other hand segments the population and inevitably results in unequal access, usually for vulnerable populations.

In addition, a single-payer allows a single institution to have control over all the parameters or elements of health reform. In implementing health reform in the former Soviet Union, changes in health financing and provider payment systems are necessary, but not sufficient. The structure of the health delivery system also has to change. A single payer can restructure the health sector as well as introduce new provider payment systems. In addition, the single payer can address issues ranging from setting broad health policy, to improving clinical practices and quality, to establishing and improving health information systems.

In summary, Kyrgyzstan has taken major steps toward institutionalizing health reform at the national level and enhancing sustainability in the long-term. Kyrgyzstan, along with all countries in the former Soviet Union, faces enormous hurdles in restructuring the health sector to provide lower cost, higher quality health services to the population. Kyrgyzstan's step-by-step approach has allowed the country to keep moving forward in health reform, identifying and removing hurdles along the way. However, the job is not finished and there are many important obstacles that still need to be addressed.

Beginning the process of institutionalizing the health reforms at the national level facilitated the ongoing process of rolling-out the health reform model across oblasts. The next section discusses roll-out to South Kyrgyzstan.

Roll-Out of the Health Reform Model to Osh and Jalal-Abad Oblasts

In early 1998, the MOH requested assistance from USAID to begin the process of rolling-out or extending the health reforms to South Kyrgyzstan – Osh and Jalal-Abad Oblasts. As South Kyrgyzstan is large, containing approximately 50% of the population, it was decided to roll-out in stages using pilot sites. There are currently four pilot sites in South Kyrgyzstan. Osh Oblast pilot sites are Aravan and Now-Kat Rayons. Jalal-Abad pilot sites are Jalal-Abad City and Bazaar-Korgon Rayon.

Similar to the World Bank collaboration, ZdravReform developed a collaborative relationship with the Asian Development Bank (ADB). The ADB has designed a Social Sector Project in South Kyrgyzstan, focusing on health and education. In health, the ADB Project focuses on rural infrastructure. It provides equipment and renovations for newly formed FGPs in rural areas. The Osh and Jalal-Abad FGPs are involved in decisions concerning equipping and renovating rural FGPs. It is expected that the second World Bank Project planned to start in 2001 will finish equipping and renovating urban FGPs.

Since 1998, ZdravReform has collaborated closely with counterparts in Osh and Jalal-Abad to establish the FGPA and Hospital Association as health sector NGOs serving as vehicles for health reform, formed 64 FGPs, and provided clinical training for more than 300 FGP physicians. ZdravReform and oblast stakeholders also have initiated health promotion campaigns targeting the population, collected and analyzed health sector data, facilitated the implementation of national provider payment systems, and developed and implemented new health information systems.

Although the health reforms in Osh and Jalal-Abad Oblasts have been initiated very rapidly, much work remains. The health reforms in the pilot sites need to be deepened and then widened or rolled-out throughout South Kyrgyzstan. In addition, the health reforms need to be integrated into the ADB Project.

Initial Stages of Roll-Out to Naryn and Talas Oblasts

Institutionalization of health reform in a national policy and legal framework has resulted in the initialization of the first stages of health reform in the two remaining Kyrgyzstan oblasts of Naryn and Talas. Starting in the fall of 1999, the ZdravReform Program contributed to developing the pre-conditions for health reform in Naryn and Talas by starting to establish FGPA's, forming FGPs, beginning to collect data for analysis, and beginning to include participants in training seminars.

Impact Of Health Reforms on Health Sector Efficiency in Kyrgyzstan

Two exemplary impacts of the health reforms on the efficiency and effectiveness of the health sector are presented below.

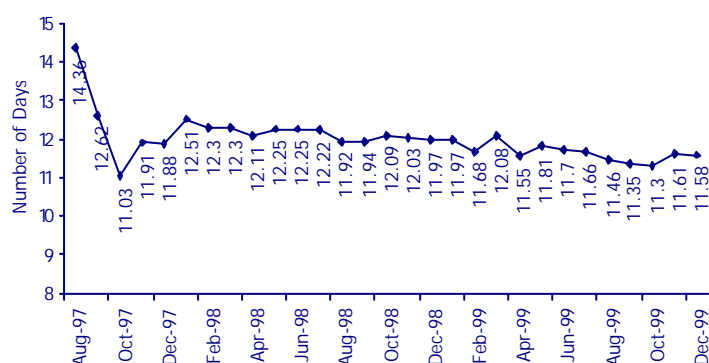
Hospital Length of Stay

As mentioned above, health reform objectives are aimed at strengthening PHC through the formation of new FGPs and shifting resources from inpatient or hospital care to PHC. The old hospital payment system was a budget system that allocated funds based on production input measures such as number of beds. It contained a direct financial incentive to increase and maintain capacity. The result was a health service delivery system with too many hospitals and too many beds. A new case-based hospital payment system was introduced in Kyrgyzstan to contribute to the rationalization of the hospital sector and a shift of resources to the more cost-effective PHC sector. The hospital payment system creates competition among hospitals and allows them more management autonomy to allocate resources more effectively.

One indicator of hospital efficiency is length of stay (LOS), the average number of days each patient remains in the hospital. The LOS in Kyrgyzstan is approximately three times higher than the United States. The old hospital payment system contained financial incentives to increase LOS, while the new case-based hospital payment system contains financial incentives to decrease LOS.

The HIF implemented a national case-based hospital payment system in August. Approximately 60 general hospitals throughout Kyrgyzstan now are being paid under this new hospital payment system. Figure 1 shows the change in LOS across these 60 general hospitals over the last two and a half years, from implementation of the hospital payment system

**Figure 1: Hospital Average Length of Stay
Kyrgyzstan, 1997-99**



in August 1997 through December 1999. The source of information is the hospital payment information system developed and implemented by the HIF with technical assistance and training from the ZdravReform Program. By December 1999, it contained over 600,000 hospital cases that represent bills submitted for each hospital case in order to receive payment.

The average LOS in the 60 general hospitals included in the new case-based hospital payment system has decreased from 12.61 days in January 1998 (the point at which it is considered that enough hospitals and cases were contained in the system for it to be representative) to 11.58 days in December 1999 – a decrease of 8 percent. More importantly than the absolute decrease is the stability of the trend, there has been a stable and consistent decrease in LOS since the implementation of the new hospital payment system by the HIF.

This decrease in LOS means that hospitals are functioning more efficiently, creating savings that can be reinvested in improved health services for the population. While the decrease in LOS does not result in realization of savings until hospitals rationalize or downsize their capacity, the competition and management autonomy created by the new hospital payment system encourages hospitals to undertake this rationalization.

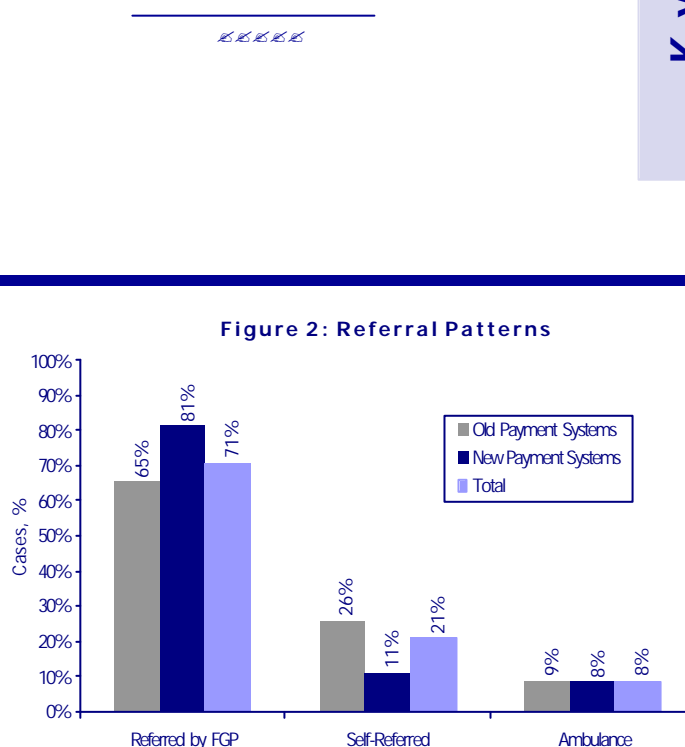
Primary Health Care Referrals

One way to evaluate the impact of health reform on health delivery system effectiveness is the level of referrals from PHC to other levels of the health delivery system. While primary health care is the most cost-effective level of service, the PHC sector in Kyrgyzstan is underdeveloped and needs to be strengthened. FGPs are being formed to strengthen PHC and expand its scope of service, meaning that medical conditions formerly treated in hospitals can be treated in FGPs. The level of referrals indicates whether PHC is expanding its scope of service.

To effectively strengthen PHC, the health delivery system must be strengthened and financial incentives introduced through new provider payment systems to encourage health providers and the population to utilize PHC services. These financial incentives to guide utilization of health services are being introduced in Kyrgyzstan through the new case-based payment system for hospitals and the new capitated rate payment system for FGPs.

The HIF introduced a policy into its new case-based hospital payment system affecting how the health delivery system is utilized. Hospital cases would not be paid unless an FGP or other outpatient provider referred the patient to the hospital. This policy and the attached financial incentive strongly encourage the population to use PHC services rather than self-refer to hospitals. The combination of strengthening PHC and introducing financial incentives to utilize PHC results in a more efficient health sector providing lower cost, higher quality health services to the population.

Figure 2 shows the impact of the HIF policy on self-referrals. The hospital payment database containing 486,000 cases through August 1999 is the source of referral data. The clinical information form or bill contains mandatory information on the source of referrals to the hospital. The sources of referral in this chart are referral from a FGP or other outpatient provider, self-referral meaning that the patients refer themselves to the hospital, and ambulances. Under the new hospital payment system, the level of self-referrals dropped from 25.63% to 10.64% over the time period from August 1997 to August 1999. This is a 58% drop in the rate of self-referrals meaning that patients are utilizing PHC more often and the health delivery system is beginning to function more effectively.



Building a Foundation for Health Reform in Uzbekistan

Introduction

Uzbekistan was initially reluctant to embrace a comprehensive health sector reform policy. Intensive technical assistance under the USAID/ZdravReform project did not begin in Uzbekistan until 1998. Despite initial reticence, the Government of Uzbekistan has made significant strides in developing strategies to improve rural infrastructure and reform the health sector, and in beginning to implement reform strategies in pilot demonstration sites in close collaboration with the World Bank, USAID, and other donors.

USAID agreed with the Government of Uzbekistan and the World Bank that it would use the ZdravReform experience in Kazakhstan and Kyrgyzstan to develop a comprehensive model of rural health reform in Ferghana Oblast. At the Government's request, ZdravReform agreed to pilot test the reform model in three experimental rayons in Ferghana Oblast. It was envisioned that the health reforms piloted in Ferghana Oblast would serve as a model for extension to the rest of Ferghana Oblast and to Navoi and Syr Darya Oblasts over time, and, ultimately, would determine the direction of national primary health care reform.

The reform model being implemented in Uzbekistan is based on the regional model, building on lessons learned during ZdravReform implementation processes in Kazakhstan and Kyrgyzstan and adapted to the Uzbekistan context and a strictly rural setting. The model includes:

- ✍ Establishing a legal basis for reforms and monitoring and evaluating the reform process
- ✍ Restructuring the PHC delivery system and strengthening its clinical capacity
- ✍ Introducing new payment systems for rural PHC facilities based on capitation, new management mechanisms to support new payment systems, and new computerized health information systems
- ✍ Involving the population in health reform

To date, significant progress has been made in laying a foundation for health sector reform in Ferghana Oblast and at the national level. Forty-five rural PHC facilities have been registered as independent juridical entities that receive financing directly from the Oblast Health Department on a per capita basis. Over 100

doctor/nurse teams from these facilities received clinical training and skills upgrades that address the major causes of morbidity and mortality in Ferghana Oblast. Health promotion and community involvement efforts have encouraged the rural population to take more responsibility for their own health and the health of their communities.

Policy Environment

Health reform efforts in Uzbekistan have been guided by a 1996 government decree announcing a new program to strengthen the government infrastructure in rural areas, where almost 70% of the population lives. The program included a plan to build new health facilities in rural areas known as rural physician posts (the Russian acronym is SVP). The Government of Uzbekistan subsequently asked the World Bank for funding to support this program. In 1998, a comprehensive Presidential Decree was issued on reforming the health sector.

The Decree laid out the fundamental directions for reform in the health sector – PHC (especially in rural areas) and emergency care – and guaranteed that these services should continue to be provided to the population for free. Inpatient and tertiary care gradually would be converted to a fee-for-service basis, many facilities would be privatized, and mandatory and voluntary health insurance would be introduced to help spread the rising out-of-pocket costs for health care consumers and vulnerable populations.

In rural areas, reform of the PHC system, at least in pilot oblasts, resulted in significant restructuring and streamlining of the health delivery system. Feldsher (a mid-level provider) posts, rural ambulatories, and rural hospitals were closed to make way for a new two-tiered system consisting of the rural physician post (SVP) and the central rayon hospital. The SVP would be staffed by specialists retrained as general practitioners and by a new multi-profile nurse known as a universal nurse. The SVP would provide health prevention and promotion services to the population in its catchment area and serve as the first point of entry into the health system. A new design and staffing schedule was developed for the SVP and construction of these facilities began around the country in late 1998. Closures of facilities in pilot oblasts soon followed SVP construction, but

unfortunately savings generated by this facility rationalization were not significant because the number of health personnel was not significantly reduced nor were the limited savings channeled back into the health sector. USAID/ZdravReform, the British Department for International Development (DFID), and the European Union/TACIS have provided technical assistance in PHC reform efforts.

Reform of the emergency care system involved construction of national, oblast, and rayon level emergency care centers, in some places attached to existing hospitals, in other places completely new independent vertical structures. The USAID-funded American International Health Alliance (AIHA) provides technical assistance to the Government of Uzbekistan to reform the emergency care system in Ferghana Oblast. AIHA and ZdravReform are working together to ensure that a complete referral system is in place, starting from the PHC level and referring up to the oblast emergency care center.

Although the presidential decree is quite progressive and comprehensive, topics covered by the decree that have not received attention from donor organizations have not been fully planned or implemented due to limited capacity and resources within the MOH to guide the health reform process. Increased attention to privatization and the introduction of fees for inpatient and tertiary care services is needed urgently, however, in order to keep MOH resources in line with its priorities in PHC and emergency care.

History of Health Sector Reform

For context, it is important to understand the lengthy process that led to the eventual project that is currently operational in Ferghana Oblast. When the ZdravReform project was developed in 1994-5, USAID envisaged that intensive health reform demonstration sites would be developed in Uzbekistan, as well as in Kazakhstan and Kyrgyzstan. The Government of Uzbekistan, however, initially expressed little interest in working on health reform. Simultaneously, despite ongoing discussions starting in 1992, the Government could not agree to a common strategy with the World Bank to develop a health sector loan for Uzbekistan. The Government was interested in receiving World Bank financing only to support the development of domestic production of pharmaceuticals, while the World Bank also was advocating for broader and more systemic health reform.

A breakthrough was reached in late 1996 when the Government approved its new program to strengthen the government infrastructure in rural areas, and build new rural physician posts, and subsequently asked the World Bank for funding to support this program. The World Bank agreed to support this process if a health reform component was included in the project, focusing on broader system restructuring and introduction of financing and management reforms that would lead to a more sustainable health care system. In late 1998, the Government agreed that financing reforms might be needed, but requested that they be tested as an experiment in three rayons in each of the three pilot oblasts. After two years these financing and management “experiments” would be evaluated to determine if they would be adopted and rolled out. Abt Associates Inc. won the Japanese grant to develop the health sector loan project.

In 1997 the Government of Uzbekistan and the World Bank requested USAID technical assistance through the ZdravReform Program to support the financing and management experiments. USAID agreed to begin the experiments in Ferghana Oblast as the lead oblast, and also agreed that the reforms would begin before the World Bank loan was finalized and funds began to flow. USAID/ZdravReform opened an office in early 1998 to begin implementing the financing experiments in three pilot rayons in Ferghana Oblast – Beshariq, Quva, and Yazavan.

The World Bank-financed Health Reform Project became effective in May 1999. The Government of Uzbekistan borrowed \$30 million to support its PHC reform efforts in the rural areas of three pilot oblasts – Ferghana, Navoi, and Syr Darya. The Government agreed to provide an additional \$40 million to build the new SVPs in these oblasts. The World Bank-financed “Health” Project was designed to support rural PHC in the pilot oblasts by providing material assistance (medical furniture, equipment, supplies, and computers), re-training doctors and nurses in family medicine, and supporting financing and management reforms in selected rayons.

Using the World Bank loan as an impetus to initiate health reforms has had mixed results. On the positive side, the loan created the opportunity and incentive to break through previous political barriers to reforms. Without this catalyst, there would have been little opportunity for reforms, particularly in financing and management. On the negative side, however,

because comprehensive health reform was a condition to get the capital investment that the government wanted, it is unclear how much political commitment actually existed for some aspects of the reform program. The government of Uzbekistan only agreed to comprehensive reforms as part of a compromise with the World Bank. The oblast level reform demonstrations, therefore, were initiated largely through top-down planning and national decrees, which did not allow for a foundation for reform, capacity for its implementation, or political will to be built gradually in the oblasts among a wide variety of stakeholders.

Summary of Accomplishments and Results

In the two years that ZdravReform has worked intensively in Uzbekistan, the program has made significant strides in implementing health reforms in Ferghana Oblast and in building political buy-in for health reform in Ferghana Oblast and at the national level. As in Kazakhstan and Kyrgyzstan, health reform efforts in Uzbekistan have been guided by the ZdravReform regional health reform model, adapted for implementation in rural areas in Ferghana Oblast. Although the depth of the commitment to the financing reforms can be questioned, there is clearly political will for the development of a strong system of rural PHC, and for giving the PHC sector increasing independence from central rayon hospitals.

The commitment to strengthening PHC has been demonstrated in Ferghana Oblast by the restructuring of the entire PHC system in the three experimental rayons, and increasing the per capita share of oblast health resources allocated to PHC in these rayons. The following sections summarize additional results at the national level and at the demonstration site in Ferghana Oblast in each of the four technical program components: 1) developing national policy and a legal framework for health reform; 2) restructuring and strengthening PHC; 3) increasing health care financing and improving resource allocation and use; and 4) ensuring population involvement in health care. Progress made in these areas has been used to increase government commitment at national and local levels for more comprehensive health reform.

Policy and Legal Framework for Health Reform

The policy and legal framework for health reform in Uzbekistan is based on the 1998 Presidential

Decree on health system reform. ZdravReform has provided technical assistance and information to improve the content of decrees, laws, and regulations at national and oblast levels designed to support implementation of the Presidential Decree, and “Health” Project and ZdravReform reform efforts. ZdravReform also supported the development of a joint working group to guide design and implementation of financing and management reforms. Finally, the project has provided assistance in developing monitoring and evaluation strategies and beginning to institutionalize these efforts with local health reform stakeholders.

Throughout 1998 and 1999, ZdravReform provided significant assistance in drafting a Cabinet of Ministers resolution and several MOH decrees to guide the actual implementation of PHC reforms in three rayons in Ferghana Oblast. The resulting resolution, decrees, and accompanying local regulations provide the legal basis to:

- ✍ Form a network of juridically independent PHC institutions in three experimental rayons of Ferghana Oblast (Beshariq, Quva, and Yazyavan)
- ✍ Increase the proportion of oblast health care funds allocated to PHC
- ✍ Pool PHC funds for the three experimental rayons in Ferghana Oblast at the level of the Oblast Health Department
- ✍ Finance all independent juridical PHC entities in the three experimental rayons according to a single per capita rate
- ✍ Add the position of financial manager to the PHC facility staff schedules
- ✍ Authorize drug procurement for PHC facilities without need for large tenders
- ✍ Create additional staff positions (economist, accountant) at the Oblast Health Department to focus solely on supporting new financing systems
- ✍ Adopt hiring criteria for new and replacement Financial Managers

A Ministry of Finance decree affecting all organizations that receive funds from the government budget reduced the number of budget chapters from 20 to four. The decree also provided a mechanism for unspent funds and savings to be rolled over into a separate bank account as a fund for facility development that can be used at the facility manager’s discretion. This progressive piece of national legislation provides positive first steps towards “chapterless” financing, granting greater

autonomy and independence to health care facilities.

In addition to providing analysis and input into national and oblast laws and regulations, the ZdravReform Program has supported the development of joint working groups to guide the implementation of financing and management reforms. The meetings are co-chaired by the “Health” Project Implementation Unit and ZdravReform and are held bi-monthly with national and oblast-level representatives from the health and financing departments. The regular meetings enhance policy dialogue and build capacity for both broad policy and planning and narrower technical issues. The health reform process in Uzbekistan has progressed to the extent that many issues needing resolution no longer fall only within the jurisdiction of the MOH. Therefore, ZdravReform has worked to ensure that all stakeholders are included in policy dialogue and processes through this consultative, participatory process.

A health reform monitoring and evaluation strategy currently is being developed with national and local authorities to report on health reform progress and inform health policy development. The strategy is based on the goals and objectives of the reform program and a conceptual framework that demonstrates how the new policies are expected to lead to the desired outcomes. The monitoring and evaluation strategy draws on existing administrative information sources, the new health management information system that is being introduced, and periodic surveys that provide more comprehensive information across points in time in the reform process.

Baseline measurements currently are being developed using a variety of data sources including oblast statistics, a series of focus groups with the population and health care workers, a survey of more than 25,000 PHC encounters, a facility survey in 83 PHC facilities, and a survey of 1200 households. The individual surveys were conducted to: 1) determine initial attitudes towards PHC; 2) compile a snapshot of service delivery and utilization patterns in PHC facilities; 3) provide baseline information on the organization and management of the facilities and the material resources of the facilities; and 4) evaluate the impact of health reforms on the health and well-being of the population that are not captured by routine administrative data. The baseline document will pull key indicators from each of these data sources to establish an early

Clinical Training Improves Screening for Hypertension

In an attempt to measure the effects of short-course clinical trainings, ZdravReform collected data from hypertension registries in facilities in experimental and control rayons in Ferghana Oblast to see if the rate of patients registered for hypertension was higher in experimental than in control rayons due to more physicians measuring blood pressure on all adult patients, a key message of ZdravReform clinical training on hypertension and cardiovascular disease.

Preliminary findings suggest that the odds of being registered with hypertension were 1.7 times greater in the experimental rayon PHC facilities than the control rayon facilities. Furthermore, a greater proportion of the cases were registered more recently in experimental rayons, suggesting that increased registration was a direct result of recent training efforts. Of all cases registered with hypertension in the past two years 76% were in the experimental rayon facilities, whereas in all cases of hypertension that had been registered for more than two years, 46% were registered in the experimental rayon facilities.

benchmark against which development and reform of the health care system can be measured over time.

Restructuring and Strengthening Clinical Capacity

The health care system was restructured in the three experimental rayons in Ferghana Oblast by closing unnecessary feldsher points (known by the Russian acronym FAP), rural ambulatories (SVAs), and rural hospitals (SUBs). Local governments constructed new SVPs or converted existing rural ambulatories into SVPs. Although construction and conversion of these new PHC facilities is behind schedule, all 45 facilities in the three rayons (12 SVPs and 33 SVA/FAP complexes) have been registered as independent legal entities eligible to receive funding directly from the Oblast Health Department rather than through central rayon hospitals.

After initial restructuring, ZdravReform and oblast counterparts worked together to strengthen the clinical capacity of health personnel and facilities from 1998-2000 in three

ways: (1) providing on-site clinical training courses; (2) providing access to international reference materials and interaction with Western General Practitioners and family physicians; and (3) providing technical assistance in pharmaceutical policy and management.

Realizing that reform of the health care system depends on the presence of skilled personnel and hoping to complement long-term General Practice re-training efforts being undertaken by DFID and the "Health" Project, ZdravReform provided a series of on-site modular short courses for key health personnel in all 45 PHC facilities in the three experimental rayons in Ferghana Oblast. From 1998-2000, ZdravReform trained more than 100 doctor/nurse teams in nine modular short courses based on international training materials.

The courses were aimed at addressing the main causes of morbidity and mortality identified in Ferghana Oblast: ARI, CDD, anemia, hypertension, reproductive health, breastfeeding, intestinal parasites, emergency medicine/first aid, and rational prescription of drugs. Course reference materials, primarily based on internationally accepted literature, were developed for participants by project trainers and national counterparts in Russian and Uzbek on

Financial managers in Ferghana Oblast confer with a Peace Corps health management volunteer



reproductive health, anemia, diarrheal disease, breastfeeding, and hypertension.

ZdravReform also provided information about Western approaches to family medicine and PHC by providing copies of Russian language medical reference books and guides for general practitioners and PHC lab specialists to PHC facilities, training SVPs, and medical libraries. ZdravReform also designed a four-week study tour on General Practice to the UK for nine rural physicians from experimental rayons in Ferghana Oblast. The study tour included a series of lectures and workshops, as well as a week-long "mini-residency" for Uzbek physicians in rural PHC clinics outside of London. In addition, visiting international consultants provided seminars to physicians, nurses, and financial managers to discuss how both roles and responsibilities of nurses and health managers must be expanded to improve PHC service delivery; suggest appropriate quality improvement mechanisms to increase the quality of care provided at these PHC facilities; and discuss how American practices and experiences can be adapted to the rural setting in Uzbekistan.

In the area of pharmaceutical policy and management, ZdravReform informally assessed drug supply and availability in Uzbekistan and in rural PHC facilities in Ferghana Oblast. The project then trained PHC physicians on rational drug prescription, drug interaction, and rational drug administration to special groups (children, pregnant women, etc.) and for specific diseases (hypertension, diabetes, goiter, and anemia). The training resulted in reports that prescribing practices had changed for hypertension and that rural physicians were beginning to prescribe two or three internationally accepted medicines to manage and treat hypertension, instead of the 10 to 12 preparations previously used. Lastly, ZdravReform and the Ferghana Oblast Hospital collaborated to establish a drug list ("formulary") for the hospital, resulting in a list of 266 drugs that, if properly implemented, will reduce excess expenditures on less effective or more costly drugs and allow local doctors to become more familiar with, and more competent in using and prescribing, selected drugs.

New Payment, Management, and Health Information Systems for Primary Health Care Entities

In addition to supporting the development of a legal framework for the reforms and assisting in the establishment and strengthening of PHC

facilities, the ZdravReform Program and the “Health” Project were successful in implementing new payment and management systems for the facilities, based on capitation. The new systems have the dual goals of increasing the resources allocated to PHC, while at the same time providing incentives to use those resources more efficiently.

New Payment Systems

In early 1999, discussions were held with officials from the Ferghana Oblast Central Bank and the Oblast Finance Department to determine a mechanism for disbursing PHC capitated budgets according to business plans developed by the facilities. Under the previous system, budgets were allocated according to strict, centrally planned budget chapters. The representatives from the oblast financial sector agreed to accept business plans in place of chapter budgets for internal allocation of PHC resources.

The per capita payment system was developed in two stages. The first stage involved calculating the pool of funds available for PHC in Ferghana Oblast according to a prescribed formula. PHC funds were then pooled for the three experimental rayons at the Oblast Health Department and pro-rated from April to December 1999. ZdravReform and the Oblast Health Department then divided the pool of funds by the total number of people in the catchment areas of the 45 PHC facilities to get a single per capita rate and developed budgets for each facility by multiplying the capitated rate by the population in the catchment area. Finally, each facility developed a business plan to determine the allocation of its capitated financing across budget chapters. Funds began to flow to facilities under the new system on April 1, 1999.

The second stage of developing the per capita payment system focused on refining the system to allocate resources more equitably using age and gender adjusters. A survey was conducted of more than 25,000 PHC encounters in Ferghana Oblast to better understand the services that were being provided in the PHC sector, how resources were being allocated, and how utilization of health care services varied by the characteristics of the population. The capitated rate, PHC budgets, and age and gender adjustment coefficients for the year 2000 then were calculated for the 45 PHC facilities in the three experimental rayons using the encounter survey data. The capitated rate increased from 365 soums in 1999 to 667 soums in 2000. Five target age and gender

New Payment Systems Increase Funds and Management Autonomy for PHC Facilities

As a result of constructing a new PHC budget pool to set the capitated rate, the share of the per capita oblast budget for PHC increased from 11 percent to 21 percent for the three experimental rayons between 1998 and 2000. The average per capita rate in the three experimental rayons increased from 225 soums in 1998 to 365 in 1999 and increased again during 2000 to 667 soums.

In 1999, the Ministry of Finance collapsed the standard twenty budget chapters for independent legal entities eligible to receive budget funding to four main chapters: salaries, social fund contributions, capital investments, and other expenditures. This granted PHC facilities more flexibility to use their resources in a more cost-effective way and was a significant first step towards a truly “chapterless” financing system for all health care organizations.

groups were identified and coefficients calculated; the Oblast Health Department planned to introduce the coefficients into facility financing in the second part of the year 2000.

In early spring 2000, ZdravReform in coordination with the “Health” Project conducted seminars in Navoi and Syr Darya oblasts to share experiences and lessons learned from health system development in Ferghana Oblast and to introduce new reform stakeholders and counterparts at oblast and rayon levels to rural PHC reform efforts, with a special emphasis on implementing new financing, management, and information systems.

New Management Systems

ZdravReform and local counterparts also succeeded in developing new management mechanisms to support the new provider payment systems. In November 1998, ZdravReform provided technical assistance to the Oblast Health Department and the Oblast Bureau of the “Health” Project in hiring financial managers to be located in PHC facilities in Ferghana Oblast. These financial managers helped manage the facilities under the new payment system.

ZdravReform provided a three-month training program for the financial managers on business planning, modern accounting practices, management information systems, marketing strategies, and health statistics. In February 1999, at the end of training, 15 financial managers were tested and certified, giving them the right to work as financial managers in the PHC facilities in the three experimental rayons. Financial managers were assigned to serve multiple PHC facilities based on the size of the population served and began to work in their facilities on April 1, 1999. With technical assistance from ZdravReform and the Oblast Health Department, financial managers have worked with head doctors of their facilities to develop business plans and budgets for 1999 and 2000.

Since hiring and training the initial 15 financial managers, ZdravReform has provided technical assistance to improve the process of hiring, training, and supporting the managers to help implement new provider payment systems. The “Health” Project, with assistance from ZdravReform and in coordination with oblast health authorities, developed guidelines for hiring new and replacement financial managers, using experience and lessons learned from hiring the initial group of financial managers. In December 1999, using the new guidelines, a committee from the Oblast Health Department, with assistance from the “Health” and ZdravReform Projects, hired six new financial managers from two rayons, bringing the total number of financial managers to 21.

ZdravReform with support from the Oblast Health Department, conducted a one-week introductory training for the six new financial managers, including modules on the health reform model in Uzbekistan, an introduction to financing and management changes under the reforms, and local accounting standards. For these courses, ZdravReform developed five modules for financial management training on PHC reforms, health financing and payment systems, basic accounting, business planning and budgeting, and general administration and human resource management. To accompany training efforts, ZdravReform collaborated with Peace Corps Health Management Volunteers to draft and distribute a reference manual in Uzbek for financial managers and head doctors in PHC facilities. The manual includes relevant legislation governing the financing and management of PHC facilities in the three experimental rayons.

ZdravReform has been working over the past two years to develop a viable and sustainable model for training new financial managers assigned to PHC facilities. Initially an intensive, three-month training focusing on introducing health management topics, basic accounting, and computer skills was envisioned. The training would end in testing and certification of financial managers, followed by their reporting to PHC facilities.

As ZdravReform discovered, preparing a large pool of new financial managers through an intensive training program was necessary as a first step in laying a foundation for the introduction of financing and management reforms. Over time, however, a more flexible and modular system for ongoing training and certification became necessary to deal with attrition as well as the hiring of new financial managers. The ongoing training will consist of an intensive two-week introductory course, followed by a number of modular courses, each lasting 1-3 days and offered once a month to all financial managers, as new or refresher training. Trainings would consist of a combination of lectures, discussion, case studies, and exams. Upon completion of the entire series of modular courses, new financial managers could be certified.

Health Management Information Systems

Simultaneously with the development of the new provider payment and health management systems, ZdravReform began to develop a new computerized health information system for Uzbekistan based on the information system being used by the Kyrgyzstan health reform program. The essence of the new approach to clinical data collection and processing is to streamline data collection, collecting only information that is relevant and essential for data analysis. Two databases comprise the information system: a population database and a clinical information database. The population database includes basic individual and family demographic information and also will track births, deaths, and migrations, which is important information both for the implementation of a per capita payment system, and for monitoring the effects of the reform program on individual health services utilization and health status. The clinical information database will provide information to the Oblast Health Department and PHC facilities on clinical utilization, including visits, referrals, and diagnoses.

In early 1999, ZdravReform and the “Health” Project developed new clinical and financial information forms for the new information system, established procedures for completing the forms, and defined the flow of information necessary to create a comprehensive population database for Ferghana Oblast. The MOH and the Oblast Health Department approved these materials. ZdravReform and the Oblast Health Department then worked with health personnel in 45 facilities in the three experimental rayons and 38 facilities in the three control rayons in Ferghana Oblast to complete population enrollment forms for the estimated 800,000 people in the catchment areas of these 83 facilities.

At the end of May 1999, ZdravReform oversaw the arrival of a server and 20 computers procured by the “Health” Project for the new Ferghana Oblast Computer Center that was set up in the Oblast Health Department Office of Medical Statistics. ZdravReform installed and networked the computers in July 1999 and installed the population database software. ZdravReform then helped to hire and train 37 temporary data entry operators to enter population data. In four months, data operators completed entering over 630,000 records (about 20% less than initial rayon census estimates) into the population database from the 83 PHC facilities in six rayons.

Once the population data entry was complete, ZdravReform began introducing the clinical information forms into the PHC facilities. In the future, this data will be entered into the clinical information database at the Rayon Computer Centers. In February and March 2000, ZdravReform provided assistance to the “Health” Project to prepare Rayon Computer Centers and to distribute computers from the Oblast Computer Center to the Rayon Centers. The project helped to hire and train six Rayon Computer Center staff from Ferghana Oblast on general computer skills, programming, and trouble-shooting, as well as on specific skills necessary to maintain and operate the newly-introduced health information system and databases. ZdravReform also began training computer specialists from Rayon Computer Centers, head doctors, and Financial Managers from all six rayons in completing patient encounter and referral forms.

Community Involvement: Small Grants and Health Promotion

ZdravReform initiated health promotion activities aimed at involving the population in



health reform efforts and in taking more responsibility for their own health. Activities included: (1) creating and strengthening the role of NGOs in community health through a small grants program; and (2) implementing broad health promotion activities.

Small Grants Program

The NGO grants program was designed to help address health problems specific to rural populations in Ferghana Oblast, to strengthen the links between the population and health care facilities, and to strengthen rural civil society. ZdravReform encouraged grant projects to be based on community health needs assessments and include the participation of health personnel, mahalla representatives, as well as the NGO. In close collaboration with Counterpart Consortium, ZdravReform helped teach interested NGOs how to conduct community health needs assessments. The two organizations then hosted a round table to identify ways that health personnel, mahallas, and NGOs could work together to improve health conditions in their communities; the roundtable resulted in a number of grant applications be written and submitted for funding.

By June 2000, ZdravReform had funded grants aimed at improving public health, totaling

Former U.S. Ambassador to Uzbekistan Joseph Presel awards a grant to a health NGO in Ferghana Oblast

approximately \$30,000, to nine NGOs and associations in Ferghana Oblast focusing on reproductive health, family planning, STIs, ARI, goiter, hygiene, and diabetes. The grant projects resulted in over 290 seminars with over 6,183 participants. In addition, ZdravReform provided direct material assistance of water pipes and pumps to seven communities providing clean water to over 25,000 people in return for mahalla agreements to finance labor costs for installation and maintenance and development of related health promotion materials on hygiene.

Health Promotion Activities

Health promotion activities also were initiated in 1999-2000. In October and November 1999, in coordination with the National Center for Health, ZdravReform translated into Uzbek and adapted WHO/UNICEF brochures on prevention and home treatment of ARI and diarrheal diseases, as well as a brochure called Keeping Children

Healthy that provided information to mothers about a number of childhood illnesses and recommends proper immunization and nutrition. Brochures were printed in December and distributed in early 2000.

In spring 2000, ZdravReform collaborated with the National Health Center to plan a multi-media information, education, and communication (IEC) campaign on control of diarrheal disease in collaboration with regional health marketing experts. The campaign was designed to provide key messages on prevention and treatment of diarrheal disease to mothers and health workers using a variety of formats, including written materials, use of mass media, lectures, and community peer education. ZdravReform, in coordination with the Republican Health Center, UNICEF, and other donors, developed and adapted materials such as posters, brochures, and television and radio spots in Uzbek on basic hygiene, breastfeeding to prevent diarrhea, and symptoms and home treatment of diarrhea targeted to mothers. A diagnosis and treatment chart on diarrhea based on WHO materials was developed and translated into Uzbek for PHC workers.

The campaign was kicked off on April 1, 2000 so that messages would reach mothers before summer when the prevalence of diarrheal disease increases in Ferghana. Surveys of mothers to measure change in knowledge due to the April campaign were implemented with the help of Peace Corps Health Volunteers in late March and again in mid-May. The survey was designed to test mothers' knowledge on causes, prevention, and treatment of diarrheal diseases. Preliminary findings suggest an increase in awareness and knowledge due to the month-long campaign.

Conclusions

Though the Government was not yet prepared to embark on systematic health sector reform in 1998, the Uzbekistan country program made significant strides in testing out an adapted regional reform model in the rural areas of three rayons in Ferghana Oblast. In many ways, the Uzbekistan program has surpassed expectations. Resources for PHC in three rayons have increased by eight percent in three years, PHC financing was distributed more equitably through a new provider payment system, and managers have greater autonomy to spend budget funds to better meet community health needs. Doctors and nurses in 45 PHC facilities have upgraded their clinical skills in anticipation

Community Knowledge on Diarrhea Prevention Increased Due to IEC Campaign

Throughout April 2000, USAID/ZdravReform conducted a multi-media information, education, and communications (IEC) campaign targeted at increasing community knowledge about diarrhea prevention, especially among mothers. The campaign included radio spots, television announcements, newspaper articles, posters, brochures, and lectures by doctors and mahalla representatives.

Results of the month-long campaign were dramatic according to surveys conducted among random samples of 240 women before and after the campaign. Eight percent more women knew the causes of diarrhea and how to prevent it. Eight percent more women could name two symptoms of diarrhea, while 15% more could name three or more symptoms. Twelve percent more women reported that they would seek medical care if there were no improvements in the health of their child after three days. Finally, 21% more women surveyed said they would give more liquids and 42% more women said they would feed the child more to avoid dehydration and weight loss while the child had diarrhea.

of new equipment and supplies. Community involvement interventions increased participation by the population in health reform efforts and provided experience and lessons learned for other countries in the region. Ongoing dialogue with both oblast and national level counterparts during pilot implementation has assured their involvement and interest in the results of reform efforts to date.

ZdravReform success in Uzbekistan can be attributed to step-by-step implementation of the regional health reform model. Initial successes in the Ferghana demonstration site, alongside political pressure from the World Bank for broad structural reform, convinced policymakers at national and oblast levels not to abandon financing and management reforms. The comprehensiveness and flexibility of the regional health reform model allowed the program in Uzbekistan to push successful components of the model forward, and buy time to convince local counterparts of the merits of broader reform.

Future technical assistance efforts should focus on continuing to build and strengthen the foundation for reforms through the partnership between the Government, USAID, and the World Bank, and expanding the reforms as the foundation is built. The foundation relies on increasing awareness about reforms among policymakers, health professionals, and the population; training in clinical areas and in financing, management, and computers; and establishing health management information systems.

Experience from other Central Asian health reform sites shows that as these foundations are built and small steps are achieved, the commitment to reforms grows, and the next steps are more likely to be driven by demand at the local level. Once the foundation is in place, policy dialogue can shift to discussion of expansion of reform efforts and USAID technical assistance throughout Ferghana Oblast and into Navoi and Syr Darya Oblasts.



Learning Lessons from Health Reform Experiences in Central Asia

Over the last five years, the ZdravReform Program and country counterparts have implemented health reforms in more than ten demonstration sites in Kazakhstan, Kyrgyzstan, and Uzbekistan in a variety of different ways, depending on local needs. Underlying all of the reform demonstrations, however, is a conceptual model of health reform that has a set of key components that do not vary in their relevance, although they may vary in how they are implemented.

These two program strategies – developing a regional health reform model and testing and refining implementation of the model in selected demonstration sites before roll-out – have contributed to the significant and sustainable results achieved. Regional implementation experience in Central Asia has led to the development of a number of key lessons learned related to these two key program strategies.

Lessons Learned from Implementing a Regional Health Reform Model

Development of a health reform model is a process that requires identifying health sector problems, determining appropriate solutions, and developing a framework or model that allows the solutions to be implemented in a cohesive and integrated manner. In response to the peculiarities of the Soviet health system legacy, ZdravReform, based on much consultation with government representatives and stakeholders throughout the system, developed a regional health reform model for implementation in Central Asia. There are three main components of the Central Asian health reform model:

- ✍ Restructuring the health delivery system and strengthening PHC
- ✍ Involving communities and the population in health issues and health reform efforts
- ✍ Implementing effective health care financing by introducing new provider payment systems and new management information systems

Improving the legal and policy framework for health reform and increasing public awareness of reform efforts are elements of each of these components. Key lessons learned from implementing the regional health reform model are summarized below.

✍ *Universal coverage targets vulnerable populations*

The health reform model was designed to retain the major advantage of the former Soviet system, universal coverage for a basic benefits package that includes integrated PHC services. ZdravReform research has shown that women, children, and the elderly are the primary users of PHC services in Central Asia. Maintaining universal coverage of these services is the best way to ensure that health care addresses the needs of these vulnerable groups. Integrated PHC is a more cost-effective service delivery model and can improve equity, quality, and consumer satisfaction. This requires matching health budget funding and the free package of health care benefits, as well as reducing the inefficiencies in the system. The ZdravReform model helps governments prioritize health budget spending and reduce health system inefficiencies to ensure universal access to high quality PHC services.

✍ *The health reform model must be comprehensive to be successful*

A second lesson that emerged from ZdravReform's early experience was that the conceptual health reform model must be comprehensive and address all aspects of the health care system. Some views of health reform focus particularly on financing reforms, because the severe under-funding and gross inefficiency of the health care system are the most visible problems. It became clear early in implementation, however, that financing reforms alone cannot bring about the fundamental changes in the delivery of health care services that are needed to improve the health of the population. In response, ZdravReform incorporated a substantial clinical program into the health reforms, focusing on the introduction of family practice and the incorporation of typically vertical programs such as infectious diseases and reproductive health into PHC. Similarly, operational experience showed the great impact of giving the population free choice of provider. Open enrollment campaigns have become a mechanism to shift power from health sector authorities to the population and encourage patients to take more responsibility for their lifestyle choices, health, and health care decisions.

✍ ***Integration of all elements of the health reform model is crucial for achieving results***

Because all parts of the health care system are intertwined, it is impossible to separate the elements of the reform model, and they must be implemented in an integrated way. As reforms are implemented in one area and changes begin to occur, other parts of the health care system are affected and must be addressed as well. For example, as new provider payment systems are introduced and economic incentives for efficiency become stronger, health facilities must have the information and management autonomy to respond to the new changes by reorganizing their services and changing their cost structures. As a further example, as resources and service delivery are shifted to primary care, clinical skills must be upgraded and clinical protocols changed in order to allow PHC to provide a wider scope of services and reduce referrals.

✍ ***Comprehensive restructuring is required for long-term sustainability***

Health reform must achieve comprehensive restructuring in order for changes to be sustainable. This includes restructuring the health system around PHC and redefining the structure and functions of health sector institutions.

Conceptually, many of the problems in the health sector are at the core of the health delivery and financing system. Addressing them requires dismantling and rebuilding the health system foundation, centered on an integrated PHC sector. This new structure of the health delivery system meets the dual goals of rationalization to allocate limited resources more effectively and creates space for new PHC practices to expand their scope of services. The inpatient sector is consolidated to consist mainly of general hospitals with outpatient departments and provides more intensive inpatient services to treat more severely ill patients. The outpatient sector also is consolidated, as polyclinics are integrated into hospital outpatient departments or diagnostic centers. Polyclinic specialists with no connection to hospitals are major targets for the rationalization of human resources. The vast majority of rationalization must occur in urban areas, particularly oblast centers, where most of the duplication of delivery structures and excess capacity is found. If health care funds are pooled at the oblast level, the savings generated from rationalization in the urban areas can be shifted to strengthen both urban and rural PHC.

Key Lessons Learned

Developing and Implementing a Health Reform Model

- ✍ *Universal coverage targets vulnerable populations*
- ✍ *The health reform model must be comprehensive to be successful*
- ✍ *Integration of all elements of the health reform model is crucial for achieving results*
- ✍ *Comprehensive restructuring is required for long-term sustainability*
- ✍ *A step-by-step implementation process paired with local capacity building increases chances for reform success*
- ✍ *The timing of introducing components of the health reform model is important*
- ✍ *Collaboration between USAID and the World Bank provides an excellent opportunity to leverage resources to create sustainable systemic change*

Establishing Sustainable Demonstration Sites

- ✍ *Visible successes in pilot sites stimulate national policy dialogue and lead to public acceptance of reforms – the “top-down, bottom-up” approach*
- ✍ *Donors play a crucial role in achieving sustainability of demonstration sites*
- ✍ *Health reform demonstrations pass through three phases: foundation-building, implementation, and deepening and widening*
- ✍ *The countries of Central Asia can learn from the health reform experiences of their neighbors*

In addition to overall restructuring of the health sector, a new role for the MOH must be created that supports the new vision of the health sector. Historically, the MOH had little say in resource allocation decisions, limiting its overall role in sectoral planning and policymaking. The result was that the Ministries of Health in Central Asia had weak policy functions and capabilities, and health reform efforts often were hindered by the limited ability of the MOH to set priorities and introduce new financing mechanisms. Health reform efforts must continue to address the relationship between the MOH and the government financial sector, and work to strengthen the MOH’s policy function and autonomy in resource allocation within the health sector. ZdravReform’s health model sought to empower the MOH by strengthening its capability to set policy and priorities for the health sector.

✦ ***A step-by-step implementation process paired with local capacity building increases chances for reform success***

The probability of program success and sustainability increases if the program develops partnerships with counterparts to actually implement health reforms rather than providing technical assistance and training through reports and seminars. Empowering counterparts to implement health reform requires establishing a step-by-step implementation process that first builds a foundation for health reform, making the evolution of reforms more inevitable, then creates small successes that lead to big successes. A step-by-step implementation process breaks down reform activities into manageable pieces. Momentum builds for reform as small goals and objectives are quickly met and future targets become more ambitious. ZdravReform experience also has shown that initial policy development and decision making processes are easier when a wide group of stakeholders are involved through regular working groups and when objective information is used to set priorities and make decisions.

Sustainability of reform efforts also requires developing the human resources capacity to implement and then expand health reforms. Health reformers in Central Asia are better at developing ideas than implementing ideas. The

Primary health care reform efforts bring health care services closer to those who need it most



management skills required to formulate and implement plans are not well developed, as the Soviet system did not put a premium on problem solving or risk-taking behavior. For successful capacity-building, it is important that the pace of reforms follow a natural progression of foundation-building and step-by-step implementation. If reforms are pushed too quickly by top-down planning and legislation, implementation gets ahead of capacity, and local partners become frustrated and are unlikely to claim ownership of the reform process. If reforms are implemented gradually and allowed to follow a natural process of expansion, sustainability is more likely. Capacity-building will be more appropriate and effective, because it will be driven by demand from local partners, as the reform process becomes more stable and their roles and responsibilities become clearer.

The demonstrations also play an essential part in capacity-building beyond the demonstration oblasts. As oblast counterparts participate in the design and gain experience with the day-to-day implementation of reforms, they become advocates for reforms and an important source of technical assistance for national policymakers, other oblasts in the country, and for other republics. Future donor-supported projects should build on this tremendous resource by using experienced reformers to implement regional projects, while continuing to cultivate the skills and training capabilities of new reformers, so the cadre of locally-provided technical assistance continues to grow.

✦ ***The timing of introducing components of the health reform model is important to maintain integrated implementation***

Another lesson from ZdravReform experience is that the timing of introducing components of the reform model is extremely important. If some elements of the reform model progress too far ahead of others, the process of integration is disrupted. One example is the timing of restructuring PHC and clinical strengthening. The restructuring of the PHC delivery system, particularly in the rural areas, is one of the least resource-intensive steps in the reform process, and therefore has often been implemented quite rapidly. Clinical strengthening occurs much more slowly, however, because it relies on freeing up resources from other parts of the health care system or on donor assistance, which is often constrained by lengthy procurement procedures. The lag between PHC restructuring and clinical strengthening can leave the newly restructured

PHC system vulnerable, and may discredit the reform process. This problem is further exacerbated if new payment systems are introduced that create financial incentives for PHC facilities to provide more services before they have the clinical capability to do so.

Operational experience also guided the timing of ZdravReform's training efforts. An initial phase of broader training on health reform concepts and the principles of family medicine were conducted at the start of the program for a broad range of health system stakeholders. Throughout initial implementation of health reforms, more practical training was conducted for health personnel and reform managers to build clinical and management skills. Skills of PHC providers needed to be strengthened in child health, family planning and reproductive health, and hypertension management before traditionally vertical programs such as treatment of STIs, tuberculosis, or drug abuse could be integrated into PHC. Following initial implementation, broader training again became more valuable, particularly seminars bringing together all stakeholders to share experiences.

✦ ***Collaboration between USAID and the World Bank provides an excellent opportunity to leverage resources to create sustainable systemic change***

The need to ensure timely material support for reforms has generated another lesson, which is that the health reform model has the greatest impact and potential for success if it is supported by the resources available through World Bank loans. ZdravReform has actively and successfully collaborated with the World Bank in Kazakhstan, Kyrgyzstan, and Uzbekistan to jointly implement the health reform model in demonstration sites in these countries.

The collaboration between USAID and the World Bank on health sector loans is an excellent opportunity to combine the material assistance of the World Bank with the technical assistance of USAID implementing partners for health reform programs. The World Bank is reluctant to lend for equipment and other capital investment without some assurance that there will be system-wide reform to ensure sustainability of the investment. The governments of Central Asia are reluctant, however, to borrow for technical assistance to implement a reform program that meets the World Bank's requirements. Providing the technical assistance through a grant to the project from USAID has proved to be an excellent

solution to this dilemma. Furthermore, USAID benefits from this relationship, because the success and visibility of its health reform programs can be boosted by the injection of political leverage and material assistance from the World Bank project.

Lessons Learned from Establishing Sustainable Demonstrations

Although country programs in Kazakhstan, Kyrgyzstan, and Uzbekistan share the same underlying conceptual model, ZdravReform did not use a "cookie cutter" approach. Rather our technical approach was adapted to fit the social, political, and economic environment in each country. Implementation of the regional health reform model began at demonstration sites. Experience and lessons learned at these sites were used to expand reform to other sites and to inform the development of national health policy. Lessons learned from implementing the health reform model in 10 sites are described below.

✦ ***Visible successes in pilot sites stimulate national policy dialogue and lead to public acceptance of reforms – the "top-down, bottom-up" approach***

The demonstration strategy allows working variations of the health reform model to be developed and tested in well-defined geographic and administrative areas. These working models generate experience and lessons learned, which can be expanded and adapted for other sites, and eventually taken to the national level. In the demonstration sites, top-down and bottom-up implementation of the integrated PHC reform model come together and bring tangible results that are both felt by health care providers and the population, and have national policy relevance. Demonstrations are effective change agents in the Former Soviet Union, overcoming many of the psychological and cultural obstacles hampering change. The nature of the still prevalent Soviet mentality requires visible successes to overcome skepticism; incremental or step-by-step approaches to forestall the tendency to implement new programs too quickly; small victories to enhance the status of progressive health reformers; and learning by doing to improve problem-solving skills and encourage risk-taking behavior.

The demonstration approach to integrated PHC has been proven effective through 10 demonstration sites that reach more than four million people in Kazakhstan, Kyrgyzstan, and

Uzbekistan. Demonstration sites have generated successes that have gained political support for reform processes. They have also succeeded in achieving visible changes in the health care system and in the attitudes of both patients and providers, which make forward progress more inevitable.

✍ ***Donors play a crucial role in achieving sustainability of demonstration sites***

Lessons from ZdravReform experience show that the role of donor support in achieving the goal of sustainability of health reform demonstrations is two-fold. First, donors can absorb some of the initial start-up costs of reforms that the health sectors of Central Asian countries do not have adequate human or financial resources to cover. In the early stages of reforms, the interest in and incentive to work on reform activities is often concentrated among a few individuals and is not widespread in government health institutions. Health reform activities are in addition to, rather than instead of, the routine work of health sector professionals, who are often poorly compensated and initially do not have the skills or desire to take on these tasks.

Donor-supported technical assistance can reduce the burden of early reform efforts by bearing much of the financial and time costs associated with start-up activities, such as research and development of technical products, establishing computer systems, and training. Donor-supported technical assistance also can play the role of catalyst or organizer of the oblast demonstration reform activities during the early phases. This is a vital contribution, because local partners may not initially have the organizational skills to plan what at first seem to be abstract activities, which are outside of their current scope of work. In addition, the technical assistance team can provide some cover for local partners while the reforms are still relatively unknown or unsupported beyond a small group of health sector leaders, and there may be some risks involved in change. If donor-supported technical assistance absorbs the costs of the early activities and provides organizational and political support, reforms are able to get off the ground and begin to take root, which is the first step toward sustainability.

The second role of donor support in achieving sustainability of health reform demonstrations is that of capacity-building at all levels of the demonstration: policymakers, operational and technical staff in health policy institutions, and health care workers. Although donor

organizations can absorb part of the start-up costs of reforms, this should be carried out in conjunction with counterparts from the demonstration areas from the very beginning. Local partners usually do not have time to devote their full attention to early reform activities, but to begin to build capacity, they must be involved in some way in all aspects of the design and start-up. Beyond the start-up phase, strengthening capacity in the demonstration is a gradual process, and begins to occur as counterparts start to gain interest in and the incentive to devote time and attention to reform activities. This capacity-building grows out of ongoing day-to-day implementation of the reforms and is supplemented by specific technical support and training activities conducted by donor-supported technical assistance organizations.

✍ ***Health reform demonstrations pass through three phases: foundation-building, implementation, and deepening and widening***

The main questions related to the sustainability of demonstrations are deciding when they are mature and how long external support should be continued. The ZdravReform Program experience shows that even after demonstrations begin to mature and are rolled out, health sector professionals throughout the country and the entire region continue to look to the demonstration for new ideas and guidance. For that reason, there is no clear endpoint for technical assistance to the core demonstrations. The core demonstrations should continue to be supported, although on a declining basis after an initial intensive period, throughout the period of donor assistance, so the reforms can deepen and continue to become more technically advanced and serve as an example for other reform activities.

ZdravReform experience in Central Asia has shown that health reform demonstrations typically pass through three distinct phases:

- ✍ Foundation-building
- ✍ Implementation
- ✍ Deepening and widening

The foundation-building phase, which typically lasts for about one year, includes creating the legal basis for the reforms at the national level and in the demonstration area, the design and preparation of all of the elements of the reform model, training, and raising awareness about reforms among policymakers, health care

workers, and the population. Activities also may include beginning to restructure the delivery system to form independent PHC practices, horizontal integration of the three core specialties (pediatrics, internal medicine, gynecology/obstetrics), upgrading general PHC provider skills through family medicine training, and design of new provider payment systems.

The implementation phase, which typically lasts about two years, begins when all or most of the elements of the health reform model begin to function and receive independent funding. This phase is characterized by intensive technical assistance and training. There can be frequent and rapid changes during this period, as implementation begins to yield experience and modifications are made in how the elements of the reform model are implemented. In addition, local capacity begins to grow rapidly, and decisions about implementation increasingly are driven by observations and recommendations of local partners.

During this phase, PHC practices begin to expand their scope of services, as clinical training continues and more equipment is provided. Infectious disease and reproductive health services begin to be incorporated into PHC. The payment systems begin to function, and practice managers start working in the PHC practices. Information systems begin to operate and are expanded and refined. Activities to increase population involvement are intensified, and open enrollment is conducted as appropriate to the local environment.

After about two years, implementation of the reform model begins to stabilize and the depth of local capacity increases. At this stage of reforms, the core demonstration is deepened by increasing the scope and technical sophistication of the reforms, and the demonstration is widened by rolling out to other geographic areas. Quality improvement is deepened through intensive work within health facilities changing how

medicine is practiced and how providers relate to patients and communities. Provider payment, information and quality systems are refined and made more sophisticated. It is important that the reforms also be deepened politically and institutionally through the incorporation of experience from the demonstration into national level policies.

✍ ***The countries of Central Asia can learn from the health reform experiences of their neighbors***

The Central Asian republics have similar problems and look to each other for solutions. All five countries watch the health reforms implemented in other countries closely. They learn from each other's mistakes and can share technical products to plan and implement reforms. The policy debate on health insurance in Uzbekistan and Tajikistan, for example, has benefited from the experience of Kazakhstan and Kyrgyzstan. If one country successfully implements an intervention, the probability increases that other countries also will implement the same activity. Over the last few years, the major request from the most progressive health reformers in each country has been for more regional seminars and other activities. These regional activities allow reformers from each country to share experiences and work out solutions to common problems.

It is not possible to overestimate the impact on all of Central Asia of having one country stand out as a leader in health reform. Kyrgyzstan has filled this role in Central Asia over the last few years. Countries including Russia, Ukraine, Mongolia, Tajikistan, Kazakhstan, Uzbekistan, and Turkmenistan have sent representatives for site visits of the Kyrgyz reforms. All the other Central Asian countries look to Kyrgyzstan to learn from their mistakes and replicate their successes. In other words, the successful reforms in Kyrgyzstan raise the bar and open the door to similar successes in other countries.



List of Acronyms Used

AHC	Agency for Health Care in Kazakhstan
AIHA	American International Health Alliance
ARI	Acute respiratory infection
CDD	Childhood diarrheal disease
DFID	Department for International Development (UK)
FAP	Feldsher/midwife point (Russian acronym)
FGP	Family Group Practice
FGPA	Family Group Practice Association
FMTC	Family Medicine Training Center
HIF	Health Insurance Fund
IDS	Intensive Demonstration Site
IEC	Information, education, communication
LOS	Length of stay
IMCI	Integrated Management of Childhood Illnesses
MHI	Mandatory Health Insurance
MOH	Ministry of Health
NEM	New Economic Mechanisms
NGO	Nongovernmental organization
PHC	Primary health care
SES	Sanitary Epidemiological Station
STI	Sexually-transmitted infection
SUB	Rural hospital (Russian acronym)
SVA	Rural ambulatory (Russian acronym)
SVP	Rural doctor point (Russian acronym)
USAID	U.S. Agency for International Development
WHO	World Health Organization